MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before admission) a. COUNTY b. COUNTY Carroll Balto, Co. MARYLAND Maryland c. CITY OR TOWN (II outside corporate fimils, write RURAL and give nearest town b. CITY OR TOWN (if outside corporate limits. by the c. LENGTH OF STAY IN 16 write RURAL and give nearest town) 1 mo. 24 dys Sykesville Baltimore 34 ed. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital 9033 Simms Avenue 3. NAME OF 4. DATE Month DECEASED OF compl DEATH pa (Type or print) July 25 Charles Harold Adams and cor 9. AGE (In years | IF UNDER 1 YEAR B. DATE OF BIRTH 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Months | Days White Male WIDOWED [ December 23, 1879 гетоме 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY 10b, KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) dona during most of working life, even if retired) Machinist & Letter Carrier Nebraska 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William Adams Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give war or dates of service) Springfield Hospital Records No 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: Mesenteric thrombosis IMMEDIATE CAUSE (e) DUE TO Arteriosclerotic cardiovascular disease Conditions, if eny, which geve rise to immediate ceuse DUE TO (a), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY C.B.S. senile brain disease. CERTIFIC 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of itam 18.) 2De. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY 2Dd. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) Month, Day, Year factory, street, office bldg., etc.) While Not While Hour a.m. at work et work DIRECTOR ATTENDING DIRECTOR T PHYS. PHYS. FUNERAL 22d. ADDRESS 22c. PHYSICIAN'S Springfield Hospital, Sykesville, Md. Julian Radzykewycz, M.D. 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23d. LOCATION (City, town or county) REMOVAL (Specify) J. St. John's Lutheran Blenheim. Buria 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

VR A15 (4) 15M 9/60

PERFORMED?

NO A

(Stata)

22b. DATE 7-25-6 SIGNED

a. IS RESIDENCE

19 61

IF UNDER 24 HRS.

Hours

INTERVAL BETWEEN ONSET AND DEATH

days

vears

U.S.A.

ON A FARM? YES NO

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## RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence befo a. COUNTY b. COUNTY within 24 hours Carroll MARYLAND Marvland b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) by an write RURAL and give neerest town) .5 7 Sylvesville months Baltimore filled d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street address) d. STREET ADDRESS State Hospital Rossiter 3. NAME OF DATE paper 72 DECEASED OF сошру (Type or print) DEATH carbon p Josephine A DAMS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (In years | IF UNDER 1 YEAR 5. SEX 8. DATE OF BIRTH last birthday) pue Months Devs WIDOWED DIVORCED female 10a, USUAL OCCUPATION (Give kind of work physician гетоме 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) School Teacher Marvland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME death affending John Adams Mary Taylor 1 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yas give wer or dates of service) Springfield Hospital ending physician. been signed by the Records 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia. cremation, burial-transit DUE TO affending Conditions, if any, which geve rise to immediate cause DUE TO (e), steting the underlying certificate has by use as the bur burial, ceuse lest. hospital or PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY CERTIFICATION as of CBS assoc. with senile brain disease, with psychotic reaction. P 200. ACCIDENT WAS UNDERLYING P OR CONTRIBUTING CAUSE OF DEATH the TOR: After t MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Dey, Yeer factory, street, office bldg., etc.) While Not While Hour a.m. et work at work TOR: saw the deceased alive on.... 22a. SIGMATURE ATTENDING MED. STAFF DIRECTOR PHYS. PITAL Page 4 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type Julian Radzykowycz, M.D. Springfield Hospital, Sykesville, Md. 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, | 23b. 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) -5 0 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) DATE JUL 25 '61 15M 9/60 arthur S. Kraus

a. IS RESIDENCE ON A FARM? YES NO Y

19 67

IF UNDER 24 HRS.

Hours

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? NO T

> > (Stete)

22b. DATE

(State)

SIGNED

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE 7776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HFALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If Institution, Residence before edmission) l director. Page for your files. e. COUNTY b. COUNTY Carroll Maryland Balto City MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) Sykesville 5yrs.lmo. Baltimore Board d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS . IS RESIDENCE ON A FARM? 2136 St. Paul St. Springfield State Hospital YES NO K 3. NAME OF Middle Last 4. DATE Month DECEASED OF Thomas Earl 1961 Adams July (Type or print) DEATH 6, with 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthdey) 2 wit vin pencil in Item 18. Give Pages 1, 2, and Office along with form PM3. Page 5 may burial-transit permit. File pages 1 and 2 winnoval, and in any event within 72 hours Months White May 9, 1906 Male WIDOWED 3 DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Checker for freight company. U.S.A. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME James B. Adams Agnes Ellis 15. WAS DECEASED EYER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyesgivewerordelesofservice) Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED 8Y: Minutes Asphyxia IMMEDIATE CAUSE (e) DUE TO Bronchial occlusion Conditions, if eny, which (b) the word "pengeve rise to immediate cause "pending" DUE TO (e), steting the underlying Aspiration of food used ion, o PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0): 19. WAS AUTOPSY CERTIFICATION C.B.S. assoc. with CNS Syphilis, meningoen cephalitis with psychotic PERFORMED? cremati YES O NO . reaction. 20a. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) Page 3 Apparently aspirated food ease execute the certificate, writing should be forwarded to the Chief I FUNERAL DIRECTOR: Page 3 s 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 1 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) Not While Hour e.m. et work - et work S.S. Hospital Sykesville Carroll prior 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X Inquiry X and in my opinion Natural causes Accident X Suicide Homicide Undetermined manner death resulted from: CHIEF MEDICAL EXAMINER ACTUAL designated ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINER'S James T. Marsh. M.D. NAME (Type) Address (Street, city, town, or county) 22c. NAME OF CEMETERY OR CREMATORY 220. BURIAL, CREMATION, 22d. LOCATION (Eity, town, or country) REMOVAL (Specify) 0 Maren 5 g 4 5 240. REC'D 8Y REGISTRAR | 24b. REGISTRAR'S SUSTIATURE 23 FUNERAL DIRECTO ADDRES8 VS. A15ME 5M 7/59 arily & the

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requires that the death

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND	STATE	<b>DEPARTMEN</b>	T OF HEALTH
AND OF STATISTICAL	DECEADOR	ANID DECODDS	DALTIMODE & MANDE

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

	7778	CERTI	FICAT	E OF DEATH				0	776	39_
1. PLACE OF DEATH o. COUNTY Carroll		MAI	RYLAND	usual residence (wo a. STATE Maryland	here decease	b. COUNTY	on: Residenc	e before	e admiss	ion)
b. CITY OR TOWN (IF	outside corporate limits,	write c. LENGTH OF STA	Y IN 1b	c. CITY OR TOWN (If	outside corpo	rote limits, write R	URAL and g	ive near	est town	1)
(Rural) Syke		4v lmo. 1	bo	Baltimore		3	V01.	4		
d. NAME OF HOSPITA	L (If not in hospital, give	street oddress)	- h :	d. STREET ADDRESS	tt St			•	ON A	FARM?
3. NAME OF	First	Midd	10/	Lost Lost	4. DATE	Mon	*h	D		Yeor
DECEASED (Type or print)	Max	Milds	1	Berger	OF DEATH	7		10	)	19 61
5. SEX	6. COLOR OR RACE 7	MARRIED NEVER MARI	RIED   B.	DATE OF BIRTH	12	9. AGE (In years last birthdoy)	Months	Days	Hours	ER 24 HRS
male	W177 00	IDOWED DIVORO		10-18-1887	1/	73/4 yrs.		0073	110012	771111.
10a. USUAL OCCUPATION during most of working Salesman	N (Give kind of work doning life, even if retired)	10b. KIND OF BUSINESS	OR INDUSTR	Poland	or foreign c	ountry)		J.S.		COUNTRY
13. FATHER'S NAME				14. MOTHER'S MAIDEN I	NAME	195 Tal				
Israel B	erger		10	Sophia	Friedn	nan				
15. WAS DECEASED EVER	-			DRMANT Hospital rec		Addı	ress			
Conditions, if on gove rise to im couse (o), stoting the lying couse lost.	mediate DUE TO	due to art	erioso	in due to a	rterio	sclerosi			PEREO	ths
PART II. OTHE  20g. ACCIDENT WAS OR CONTRIBUTING I (IF EITHER, NOTIFY N HOUR O. m. P. m.	CAUSE OF DEATH	20d. INJURY OCCURRED While Not while of work	20e. PLAC	(Enter noture of injury in E OF INJURY (Home, forn ry, street, office bldg., etc.	n, 20f. (City		(C	ounty)		(Stote
21. 1 certify that saw the decease 220. SIGNATURE	suo Takahas	attended the deceased y 10 19 61 an	M.	D. ATTENDING D MPHYS. 22d. ADDRESS Springf	M, from IRECTOR  ield S	staff PHYS. X	pital	date	221 10-6	obove b. DATE SIGNED
24. JUNERAL DIRECTOR'S	SIGNATURE	2100 Est	2001	PL 250. REC	D BY REGIST		STRAR'S SIG			

VR A15 (4) 15M 9/59

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RYLAND STATE DEPARTMENT OF HEALTH

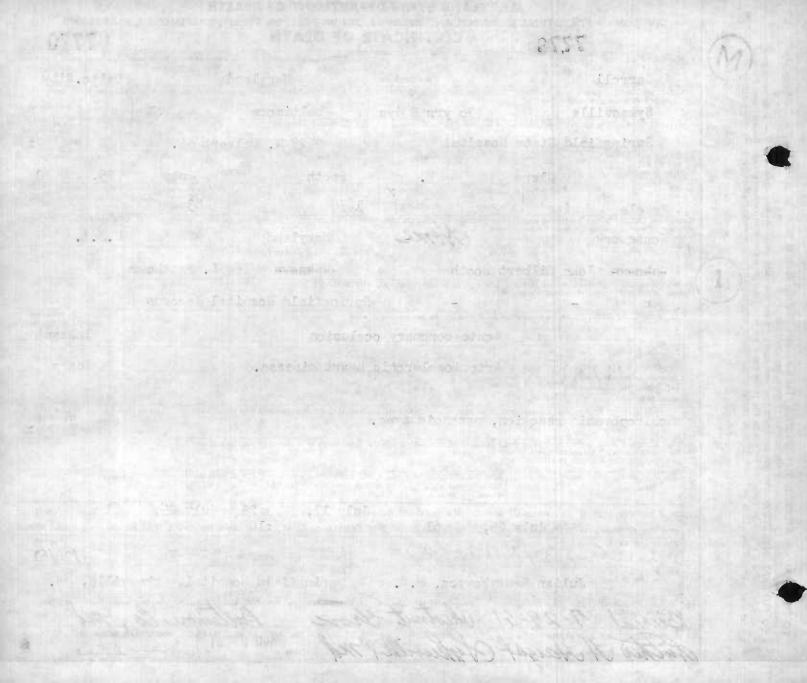
2. USUAL RESIDENCE (Where decessed lived, If institution; Residence before admission) Balto, City c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town a. IS RESIDENCE ON A FARM? YES NO TO 19 61 IF UNDER 24 HRS. 9. AGE (In yeers | IF UNDER 1 YEAR Months Hours 12. CITIZEN OF WHAT COUNTRY? U.S.A. Ida I. Matthews Springfield Hospital Records INTERVAL BETWEEN ONSET AND DEATH Instant Years PERFORMED? NO X (County) (Stata)

22b. DATE SIGNED

Springfield Hospital, Sykesville, Md.

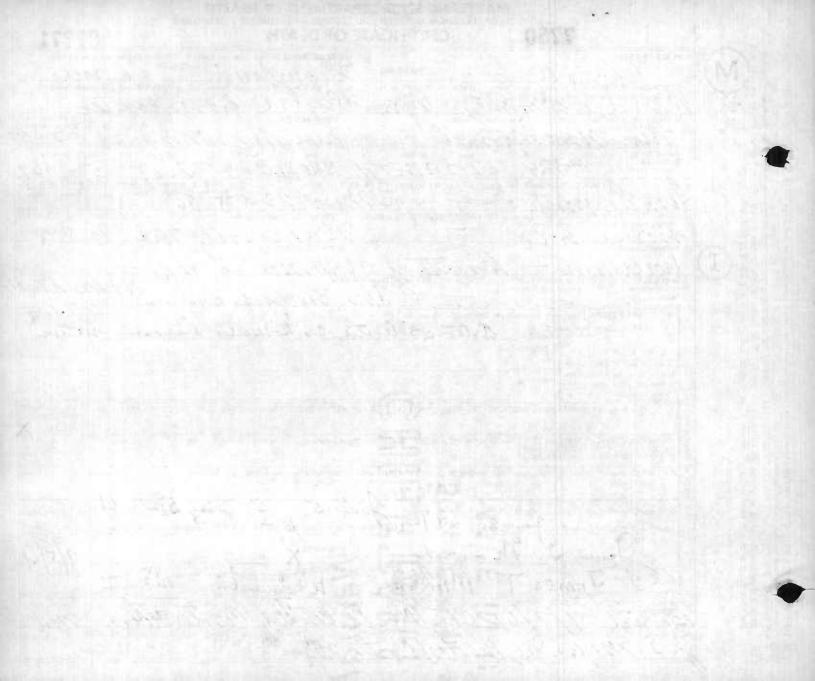
23d. LOCATION (City, town or county)

worms & Thous



CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY **b.** COUNTY MARYLAND the funeral should be fi CLTY OR TOWN (If outside corporate limits, write RURAL and give nearest tawh) b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 RURAL and give pearest Jawn) H. NAME OF HOSPITAL (If not in haspital, give street address STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? by 12 YES NO puo 4. DATE NAME OF Middle Last Month Day Year DECEASED OF DEATH Pages (Type or print) ij DATE OF BIRTH 9. AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS letely 6. COLOR OR RACE MARRIED | last birthday) Manths Days Haurs WIDOWED A DIVORCED of campl papers USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Store or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) oud 72 13. FATHER'S NAME THER'S MAIDEN NAME 14. Cor physician within certificate remove 15. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 127 INFORMANT Address event, 6 ease requires that the death attendi INTERVAL BETWEEN 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEAT ā PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o **DUE TO** by After this certificate has been signed by hed for use as the burial-transit permit. Canditians, if any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. ar attending physician 20 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO PHYSICIAN: The cremati 20a. ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) use as the 20c. TIME OF INJURY 20e. PLACE OF INJURY (Hame, farm, 20f. (City or tawn) Manth, 20d. INJURY OCCURRED Day, Year (County) (State) factory, street, affice bldg., etc.) Haur a.m. While Nat while at wark at work p. m 21. I certify that (I) (this hospital) attended the deceased frage saw the deceased alive an and that death accurred dis M, from the causes and an the date stated above. O FUNERAL DIRECTOR: 22a. SIGNATUR ATTENDING M.D. PHYS DIRECTOR PHYS. elained 22d. ADDRE should 23d. LOCATION (City, town, or county) 23a. BURIAL, CREMATION, 23b. DATE, THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) page EMOVAL (Specify) FUNERAL DIRECTOR'S SIGNATURE 25a. RECO BY REGISTRAR 256 REGISTRAR'S SIGNATURE Clatting & Krace DATE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND



RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 7782 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PLACE OF DEATH o. COUNTY be filed MARYLAND Carroll Maryland Balto, City funerol c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporale limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) pino 3yrs.llmos.5days Baltimore 14 Svkesville d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? OR INSTITUTION Springfield State Hospital 3109 Louise Avenue YES NO TA and NAME OF Middle 4. DATE Month Yeor DECEASED 1961 July Burlage George Edward DEATH Pages (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX lost birthdoy) Months Dovs September 17.1874 Male White WIDOWED A DIVORCED | 12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) U.S.A. Maryland Laborer pan 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Car Katherine -Unknown 17. INFORMANT Address 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO No Springfield Hospital Records 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Arteriosclerotic heart disease Years IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the underlying couse lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with YES NO psychotic reaction. Bronchonneumonia. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) SD 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, 20f, (City or town) Doy, Yeor 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) Hour o. m Not while ot work ot work p. m 21. I certify that (I) (this hospital) attended the deceased from August 1 July 19 61, and that death occurred of \$25AN from the causes and on the date stated above. saw the deceased olive on July 7, FUNERAL DIRECTOR: 22o. SIGNATURI 22b. DATE SIGNED ATTENDING MED. DIRECTOR PHYS. 22c. PHYSIC 22d. ADDRESS 3 should Springfield Hospital, Sykesville, Md. Agustin delCampo. M.D. page 3 sh 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) BURIAL CREMATION. (Stote) REMOVAL (Specify) the 0 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SIGNATURE ADDRESS. FUNTERAL DIRECTOR'S VR A15 (4) arthur 9 the 15M 9/59

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eep	b. CITY OR TOWN (if outside corporete limits, write RURAL end give nearest fown)  c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (if outside	corporate limits, write RURAL and give nearest town)
ours arre	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street eddress)	e. IS RESIDI ON A FA YES NO
/2 ho	Springfield State Hospital Sykesville  3. NAME OF First Middle Last 4. DAX OF	TE Month Dey Yeer
	(Type or print) Mittie Susan Carlyle DEA	July 12 1961
	5. SEX  6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH  Female  White  Widowed x divorced May 22, 1875	last birthday) Months Deys Hours M
	10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	te, or foreign country) 12. CITIZEN OF WHAT COU
	Housewife  13. FATHER'S NAME  North Carolina  14. MOTHER'S MAIDEN NAME	u.S.A.
I	Berkley Upchurch Ursula	Zinh
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  (Yes, no, or unkown) ((fyes give werordeles of service)	Address
-/		Hospital Records
	18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c).]	INTERVAL BETWEI
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Gangrene, left leg  422.  Due to	Months
	Conditions, if eny, which geve rise to immediate couse (b) peripheral insufficiency	Months
	(e), steling the underlying DUE TO ceuse lest. (c) arteriosclerotic cardiovascular di	isease. Years
7	THE REPORT OF THE PERSON OF TH	EASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTO
V	Chronic brain syndrome, cerebral arteriosclerosis.	YES NO
	Chronic brain syndrome, cerebral arteriosclerosis.  200. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or for CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	Hour e.m.  p.m.  While Not While et work et work et work	. (City or town) (County) (Ste
	21. I certify that (I) (this hospital) attended the deceased from 6-28-, 1961, saw the deceased alive on 7-12-161, and that death occurred a6:30, 8	, to
	220 SIGNATURE	22b. D
1	Courtin elel Campo M.D. ATTENDING MED. DIRECTOR	R PHYS. 7
		Hospital, Sykesville, Md.
	Burial 7-14-6/ Upchurch	LOCATION (city, town or county) (State)
	24 FUNERAL DIRECTOR'S SIGNATURE SADDRESS ADDRESS DATE JUL 1 7	REGISTRAR 25b. REGISTRAR'S SIGNATURE 7'61 Cuthun & Kraha
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH with directar, 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) filed o. COUNTX O. STATE b. COUNTY MARYLAND funeral uld be fi b. CITY OR TOWN (If outside carporate limits, write c. CITY OR TOWN (Moutside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b RURAL and give nearest town) shauld d. NAME OF HOSPITAL (If not in hospital, give street oddress) the d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? by 12 YES NO 2. 3. NAME OF First Middle Lost 4. DATE Day Year DECEASED OF DEATH (Type or print) 196 SEX COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH (In years DER 1 YEAR IF UNDER 24 HRS campletely birthday) Days Hours after DIVORCED WIDOWED | papers. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? hours during most of working life, even/if retired) and pou 72 13. FATHER'S NAME 14. MOTHER'S MAIDEN/NAM COL physician .⊆ with remove WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address attending please CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) ÷ **DUE TO** þ Conditions, if any, which (b) gove rise to immediate per DUE TO couse (o), stoting the underlying couse lost burial-transit physicion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? has YES NO or attending 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20d. INJURY OCCURRED (State) Doy, Year (County) foctory, street, office bldg., etc.) Haur a.m. Nat while While After this at wark ot wark p. m. 21. I certify that (I) (this haspital) attended the deceased fram that (1) (wa) last saw the deceased alive in and that death accurred at causes and an the date stated above from FUNERAL DIRECTOR: 220. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. PHYS. pe M.D. DIRECTOR [ retained 22d. ADDRESS 22c. PHYSICIA should NAME (Type) 3 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23d LOCATION (Stote) page ŝ REMOVAL (Specify) 0 EUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR SIGNATURE Clillan & Thousa DATE JUL 1 VR A15 (4) 15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W, PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7784 funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before edmission) e. COUNTY b. COUNTY Balto. City the Carroll MARYLAND Marvland by the b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest lown) write RURAL and give nearest town) byrs.lmo.16days - 2. Baltimore Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS ON A FARM? YES NO Springfield State Hospital Broadway and Fairmount Avenue 3. NAME OF 4. DATE DECEASED OF (Type or print) DEATH DeWalden Chancellor July 1961 Grace and cor 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 24 HRS. 5. SEX 8. DATE OF BIRTH 9. AGE (In yeers | IF UNDER 1 YEAR last birthdey) Months | Days July 6, 1865 Female WIDOWED TO DIVORCED T 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b, KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) U.S.A. Maryland Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Addis W. Smith Arthur Smith 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no. or unkown) | (If yes give war or dates of service) Springfield Hospital Records 18. CAUSE OF DEATH [Enler only one cause per line lor (e), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: montax weeks IMMEDIATE CAUSE (a) Uremia Coma DUE TO (b) Renal insufficiency Years gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0): 19. WAS AUTOPSY CERTIFICATION YES NO TO C.B.S. associated with circulatory disturbance, with cerebral 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, ) 20f. (City or lown) (County) (State) factory, street, office bldg., etc.) While Not While Hour e.m. at work 5-31- 1955, to 7-17- 161, that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from........... 220. SIGNATUR ATTENDING STAFF PHYS. DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS Julian Radzykewycz, M.D. Springfield Hospital, Sykesvilles, Md. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23e. BURIAL, CREMATION, | 23b. DATE THEREOF REMOVAL (Specify) O in a BURIAL 7-18-61 Woodlawn Cemetery Woodlawn, Md 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) DATE JUL 1 8 '61 15M 9/60 Wm. Cook, Inc., 1217 St. Paul Street arthur S. Krays

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MARYLAND STATE DEPARTMENT OF HEALTH

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE Film G292 1. USUAL RESIDENCE (Where decessed lived, if institution, Residence before edmission) HEALTH DEPT I. PLACE OF DEATH . COUNTY b. COUNTY Page a. STATE y is necessary, director. Page Michigan Carroll MARYLAND b. CITY OR TOWN (If outside corporete limits. c. LENGTH OF STAY IN 16 c, CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town) write RURAL end give neerest town) Your Detroit Westminister d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS . IS RESIDENCE for ON A FARM? funera YES NO retained Clearview Motel State Ashton 3. NAME OF Middle 4. DATE Month Day Yeer DECEASED OF 3 to the the (Type or print) DEATH BERNARD AUGUSTA CLINGAN July 19 67 Print 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED 8, DATE OF BIRTH 5. SEX 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. may last birthday) Months Hours MIn. 2. and WIDOWED DIVORCED Male S P C 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? 11, BIRTHPLACE (Slete or foreign country) Page 72 done during most of working life, even if retired) Give Pages pages within 13. FATHER'S NAM 14. MOTHER'S 1 16 SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address (Yes, no, or unkown) | (Ifyesgivewerordetesofservice) permit. 18. CAUSE OF DEATH JEnter only one cause per line for (e), (b), end (c).] INTERVAL BETWEE ONSET AND DEATH along 5 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE IN Arteriosclerotic cardiovascular disease and DUF TO burial Conditions, if eny, which (b) gave rise to immediate cause DUE TO (e), steting the underlying 35 cause last, pesn PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): 19. WAS AUTOPSY PERFORMED? 0 the word X NO F YES Medical plnods 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert If of Item 18.) 20a, EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. EXAMINER: 300 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, ' 20f. (City or town) (County) (Stete) S 968 factory, street, office bldg., etc.) 0 While Not While Hour e.m. to the et work | et work execute the certificate, OR: 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion d DEPUTY MEDICAL forwarded in Undetermined manner death resulted from: Natural causes X Accident Suicide Homicide CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER ASSOCIATE Patho DATE SIGNED should be for SIGNATURE designal DEPORTS DESCRIPTION OF THE PROPERTY OF THE PRO Reter W. Rieckert, M.D. NAME (Type) Address (Street, city, town; or county) 220. BURIAL, CREMATION, 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State) REMOVAL (Specify) 40 9 ሗ REGISTRAR | 246. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR REC'D BY VS. A15ME Circhary & Here 5M 9/60

ND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 7787 director 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission PLACE OF DEATH a. COUNTY b. COUNTY MARYLAND Maryland Balto, Gata Carrol funeral c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 pe RURAL and give nearest town) Baltimore lyr.3mos.16days Sykesville d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO 7913 Elmhurst Avenue Springfield State Hospital 4. DATE NAME OF Middle Month Year DECEASED Elizabeth DEATH (Type or print) Sarah Cole July 19 67 Poges IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years 5. SEX last birthdoy) Months Days WIDOWED T DIVORCED [ Female White May 27, 1880 papers. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Housewife Texas 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Maggie White Spencer Warren IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address No Springfield Hospital Records INTERVAL BETWEEN 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] ONSET AND DEATH Bronchopneumonia with lung abscess IMMEDIATE CAUSE (a) davs DUE TO Rheumatic heart disease Conditions, if any, which vears gave rise to immediate DUE TO couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY psychoticerformed? Chronic Brain Syndrome associated with senile brain disease reaction 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc. Hour a.m. While Not while at work at work p. m. 21. I certify that (I) (this haspital) attended the deceased fram. March 19, 1960, ta July 5, 1961, that (I) (we) last \_\_ 1961 , and that death accurred at 9:20%, from the causes and an the date stated above. saw the deceased alive an July 5. DIRECTOR: 22a, SIGNATUR MED. DIRECTOR of 22c. PHYSICIAN' 22d. ADDRESS 3 should NAME (Type Springfield Hospital, Sykesville, Md. Campo M.D. FUNER BURIAL CREMATION 236, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or County) (Stote) poge the St REMOVAL (Specify) 0 24. FUMERAL DIRECTOR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS Cinthun & Krous VR A15 (4) 1SM 9/S9

AND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (W. o. STATE Mary 1	and the second s	COUNTY	nce before admission)
b. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) Rural, Westminster	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF Rural, West		s, write RURAL ond	
d. NAME OF HOSPITAL (If not in hospitol, give street OR INSTITUTION Westminster, Md. R.D.2 (I		d. STREET ADDRESS Westminster,	Md. R.D.2(	Union Mil	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First DECEASED (Type or print) Mary	Middle Anna	Crow1	4. DATE OF DEATH	Month July	Day Year 19 19 61
9,94 9 4	RRIED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH April 5, 188	lost b	(In years irthdoy) yrs.	R 1 YEAR IF UNDER 24 HRS Doys Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife-Housework	b. KIND OF BUSINESS OR INDU	Lancaste	r Co., Pa.		S.A.
13. FATHER'S NAME  Austin Myers		14. MOTHER'S MAIDIN		(Elizabe	th Metzlær)
(Yes, no, or unknown)   (If yes, give war or dates of service)		nformant arfield D. Cr	ow1, Westm	Address inster, M	ld. R. D. 2
18. CAUSE OF DEATH [Enter only one couse per PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o)	line for (o), (b), and (c).]	Hemoul	nege		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if ony, which gave rise to immediate couse (o), stoting the under-lying couse lost.	ypertensine	Cardio-Von	9	Preare	10 year
PART II. OTHER SIGNIFICANT CONDITION	S CONTRIBUTING TO DEATH 8U	T NOT RELATED TO THE TERM	WINAL DISEASE COND	ITION GIVEN IN PA	RT 1(o) 19. WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ESCRIBE HOW INJURY OCCURR	ED. (Enter noture of injury in	Port I or Port II of ite	em 18.)	
Hour o.m. Whi		LACE OF INJURY (Home, far octory, street, office bldg., e		)	(County) (State
21. I certify that (I) (this haspital) atte	nded the deceased fram	death accurred al	M, fram the co		L, that (I) (we) las
220. SIGNATURE	otter	M.D. PHYS.	MED. STAF		July 19,196
22c. PHYSICIAN'S L. L. Po	TTER M.	22d. ADDRESS	TTLES	TOWN	IPA.
23d. BURIAL, CREMATION, REMOVAL (Specify) Burial 7/22/61	23c. NAME OF CEMETERY St. Marys Ce	metery	Silver F	ty, town, or county)	11 Co., Md.
24 FUTSERAL DIRECTOR'S SIGNATURE	ADDRESS STATE	250. REI	101	25b. REGISTRAR'S S	

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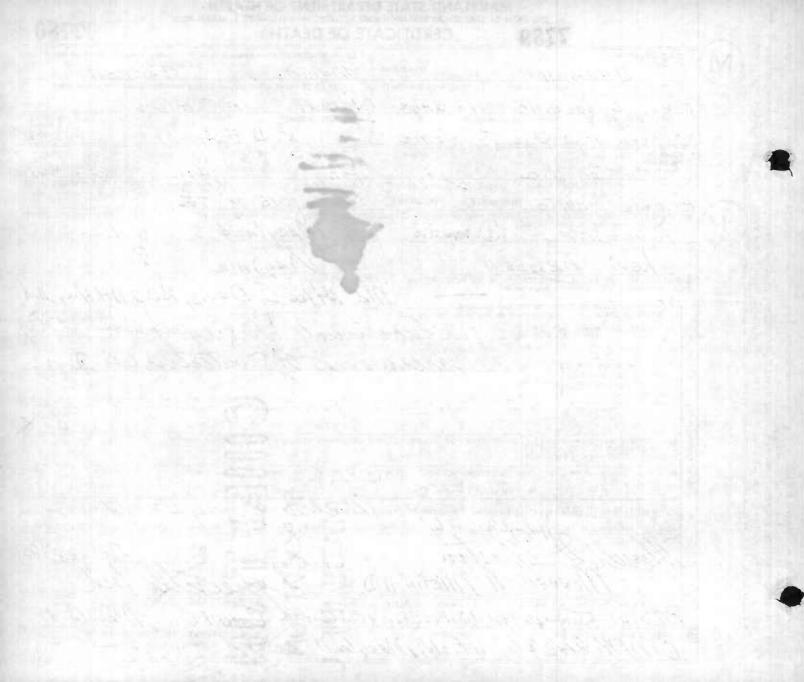
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07780

	7789 CERTIFICA	ATE OF DEATH 07780
	PLACE OF DEATH a. COUNTY  CARROLL  MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY ARRESIDENCE
1	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  RURAL and give nearest town)  OR INSTITUTION  OR INSTITUTION  A A SE GUEST HOME	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  R. D. F. D. F. Z.,  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES \( \text{NO} \) NO \( \text{P} \)
3		B. DATE OF BIRTH  4. DATE OF BIRTH  4. DATE OF BIRTH  AGE (In years less birthday)  AGE (In years less birthday)  Manths Days Hours Min.
1	da. USUAL OCCUPATION (Give kind of work done during most af working life, even if retired)  The WIDOWED DIVORCED DIVORCE	11-15-88 12 yrs.
	WAS DECEASED EVER IN U. S. ARMED FORCES? (es. no. or unknown)  (If yes, give war or dates of service)  18. CAUSE OF DEATH [Enter anly ane couse per line for (o), (b), and (g).]	INFORMANT  MR. HIRE C. DAVIS, R.D. 2. NH. HIRY, M. G. INTERVAL BETWEEN ONSET AND DEATH ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO  Conditions, if any, which gave rise to immediate couse (o), stating the under-lying couse last.  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU	orna of Sullatives Byrs.  It not related to the terminal disease condition given in part 1(0) 19. Was autops)
City City		PERFORMED? YES NO ED. (Enter nature of injury in Part I or Part II of item 18.)
140000	20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED Hour o. m. 19 While Not while ot wark 1 at wark 1	PLACE OF INJURY (Home, farm, 20f. (City ar tawn) (County) (Stote actary, street, affice bldg., etc.)
	226. SONUTURE  THE PHYSICIAN'S NAME (Type) MORREII. M. MASTIN, M.	M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. DIRECTOR PHYS. DIRECTOR DIRE
	The Practy July - 26-1961 Wintial Church	
12	I. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS MAIL	250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE Criting S. Trians

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## MARYLAND STATE DEPARTMENT OF HEALTH ON OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

	DIVISION OF	STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1	į
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Wh	ere deceased lived. If institu		odmission)
Carroll	MARYLAND	Marylan	b. count	Carroll	
b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)	c. LENGTH OF STAY IN 16	N .	utside corporate limits, write	RURAL and give neares	t town)
d. NAME OF HOSPITAL (If not in hospital, give street	L YEAR	Taneyto	wn		S DESIDENCE
OR INSTITUTION	address)	d. STREET ADDRESS		e.	ON A FARM?
22 W. Baltimore	Street	22 W. Ba	Itimore Stree	+. Y	ES NO
3. NAME OF Pirst DECEASED	Middle	Last	4. DATE Me	onth Day	Year
(Type or print) Elsie	Belle	Dutrow	OF DEATH .T117		19 67
	RIED NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In year	IF UNDER 1 YEAR IF	
Female White WIDOW	Color I had a face of	July 11. 1884	last birthday)	Manths Days H	laurs Min.
10a. USUAL OCCUPATION (Give kind of work dane 10b. during most of working life, even if retired)	KIND OF BUSINESS OR INDU	ISTRY 11. BIRTHPLACE (State	ar foreign country)	12. CITIZEN OF W	HAT COUNTRY?
	vn home	Maryland		U.S.A.	
13. FATHER'S NAME	MI DOME	14. MOTHER'S MAIDEN N	AME	UaDaRa	
77.					
Elias Singer  Is. was deceased ever in u. s. armed forces? 16.	SOCIAL SECURITY NO. 1-2	Unknown	4.1	1	
(Yes, no. or unknown) (If yes, give war or dates of service)	SOCIAL SECURITY NO. 17, I	NFORMANT	Ad	dress	
No	220-26-5668 M	rs. Myrle Devi	lbiss. Tanevt	own Maryl	and
1B. CAUSE OF DEATH [Enter anly ane cause per li	ne far (a), (b), and (c).]			INTERV	AL BETWEEN
PART I. DEATH WAS CAUSED BY:	uto Know	Oat	an acel	QNISET	AND DEATH
IMMEDIATE CAUSE (a)	accord	augura	and and	rivy Te	4 1914
4201 DUE TO D		3 + 1.		1.	-
Canditians, if any, which (b)	muny	mucis	elect	/.	2 420.
gave rise to immediate cause (a), stating the under-	5.		1	1	_
lying cause last. (c)	Rucia	level W	reund	cei 1.	> yes
PART II. OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BU	NOT RECALED TO THE TERMI	NAL DISEASE CONDITION G	IVEN IN PART 1(a) 19.	WAS PUTOPSY
PART II. OTHER SIGNIFICANT CONDITIONS					PERFORMED?
	COIDE HOW INJUING OCCUPAN	TD (F-1	test I as Best II of Store 18 1	1	2 NO
OR CONTRIBUTING CAUSE OF DEATH	CRIBE HOW INJURY OCCURRE	D. (Enter nature at injury in r	aff I af Part II at Item 16.)		
2	f.	ACE OF INJURY (Hame, farm, ictary, street, affice bldg., etc.		(Caunty)	(State)
Haur a.m. While at war	INUI WILLE	ciuty, sireer, utilice bidg., etc.			
		10/00	11 -1111		
21. I certify that (I) (this haspital) attend			76.ta_1/1	, 19/e/, that	1 / 1
saw the deceased alive on	1960 /, and that	death accurred at	W, fram the causes a	nd on the date st	ated above.
22g. SIGNATURE		/			22b. DATE
16-11. M-Va	augh	M.D. PHYS. ME	D. STAFF		SIGNED
22c. PHYSICIAN'S	// .	22d. ADDRESS		- (	
NAME (Type) 2.5, Mell	aveila	10	media		ul
22			1		
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)	23c. NAME OF CEMETERY C	OR CREMATORY	23d. LOCATION (City, tawn,	, ar caunty)	(State)
Burial 7/16/61	Keysville Cer	metery	Keysville, C	arroll, Man	ryland
24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'E		SISTRAR'S SIGNATURE	
C.O. Fuss & Son	Taneytown, Ma	rvland DATE	1 1 7 '61 0	istima & thous	
O O O I UDD & DOII	Latiny bowing with	Jamin Jan 30	So d V V	J. 100000	

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HEAL	LTHI	ATE DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Use delay is necessary, in place execute the certificate, writing the word "banding" in Bendi in Item 18. Give Pages 1.2, and 3 to the funeral director. Page 2.0	4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.	M
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VITY IN	be fo	or its designated agent, prior to burial, cremation, or removal, and in any event-within 72 hours after death.
DEP	should	r its de
H	140	0
VS.	AT5ME	1/

## MARYLAND STATE DEPARTMENT OF HEALTH

779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07782

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDEN	CE (Whare daceased livad, If Instit b. COUNTY	ullon: Residence before admission)
Carroll MARYLAND		Maryland		
b. CITY OR TOWN (if outside corporata limits, write RURAL and give neerest lown)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town)		
Sykesville	. Baati	Baatimore #14		
d. NAME OF HOSPITAL OR INSTITUTION (if not in he	ospital, give street addrass)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
Springfield State Hospital		7005 Old Harford Rd. YES NOTT		
DECEASED	Middle	Lasi	OF	Dey Year
(Typa or print) Nona	Coppage F.	EDWARDS	DEATH 7	11 1961
5. SEX 6. COLOR OR RACE 7. MARR	ED NEVER MARRIED 8	DATE OF BIRTH	9. AGE (In years   IF U	
female   white   widow	ED DIVORCED	2/17/02	59 yrs.	nths Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work dona during most of working life, even if refired)	KIND OF BUSINESS OR INDUSTR			12. CITIZEN OF WHAT COUNTRY?
Telephone operator	Virginia U.S.A.			
13. FATHER'S NAME	Charles to the state	14. MOTHER'S MAIDEN	NAME	
John A. Ferguson		Margare	Lackev	
15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16	. SOCIAL SECURITY NO. 17. I	NFORMANT	Address	
(Yes, no, or unkown) (Ifyesgive war or dates of service)	S-	minatiold He	spital Records	
1 18. CAUSE OF DEATH [Enter only one cause per		bringing in	Sp.tuar necords	I INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:				ONSET AND DEATH
MMMEDIATE CAUSE (a) Mycardial infarction.				minutes
DUE TO				The state of the s
Conditions, if any, which \ (b)				
gave rise to immediate cause				
(a), stating the underlying DUE TO				
cause last. (c)	A PRODUCTO TO DESTRUCTO		LAL DISTAST CONDITION OUTS.	NAME AND ASSOCIATION OF THE PARTY OF THE PAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?				
S CBS assoc. with Alzheimer's Disease.				YES P NO
E 20e. EXTERNAL CAUSE WAS 20b. DESC	RIBE HOW INJURY OCCURED. (E	inter nature of Injury In Pa	rt I or Part II of item 18.)	
PART II. OTHER SIGNIFICANT CONDITIONS CO.  CRS assoc. with Alzheim  206. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CO.  CAUSE OF DEATH.				
ZOc. TIME OF INJURY Month, Day, Year   20d	. INJURY OCCURRED   200. PLA	CE OF INJURY (Homa, fari	n, ! 20f. (City or town)	(County) (Stata)
Hour e.m. Whi	la Not While factork at work	ory, street, office bldg., ato	.) ]	
21. I certify that I took charge of the re	mains described above, He	ld an Autopsy ,	Inspection, Inquiry [	, and in my opinion
death resulted from: Natural causes Ty	Accident , Sulci	ide , Homicide	, Undetermined mann	ner 🗌
()		CHIEF MEDICAL	EXAMINER	
ACTUAL ASSISTANT MEDICAL EXAMINER TO DATE, SIGNED				
SIGNATURE M.D.				
EXAMINER'S			L EXAMINER	7/15/61
NAME (Type) James T. Marsh	1 22c. NAME OF CEMETERY OR		city, town, or county)  22d. LOCATION (City, town, or	country) (Slata)
REMOVAL (Specify)		CREMATORT	22d. LOCATION (City, lowin, of	country) (Stata)
Burial July 18,196	l Woodlawn C	emetery	Baltimore	. Md.
23. FUNERAL DIRECTOR	ADDRESS	24a. RE	C'D BY REGISTRAR   246. REGISTR	AR'S SIGNATURE
Hopping and Kirkleym	Glen Burnie,	Ma. DANL	17'61 consum	S. Thrank

The medical reservations of the second services and the - Added to Late of the cold of the late of E USU E LE LA LEUE DE LA CARRESTE DE LA CARRESTE LA LIBERTE DE LA LIBERT 

		7792 CERTIFICAT	E OF DEATH		0778
		PLACE OF DEATH	2. USUAL RESIDENCE (Whe		tution: Residence before ad
M	)		e. STATE	b. COUNTY	
7,1	-	b. CITY OR TOWN (if outside corporete limits,   c. LENGTH OF STAY IN 1b	Maryland c. CITY OR TOWN (If outside	corporete limits, write RU	nington RAL and give neerest town
		write RURAL end give neerest town)			
	-	Sykesville   14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Hagerstown d. STREET ADDRESS		2103-2
115					ONA
	-	Springfield State Hospital	20 Belview	Avenue	YES
-		DECEASED	Last 4. DA OF		Dey Yeer
		(Type or print) Alice Florence	Ernde	ATH July	13 19 6
	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In yeers IF last birthdey)	
		Female White WIDOWED X DIVORCED	September 26, 188		onths Deys Hours
	10a	. USUAL OCCUPATION (Give kind of work   10b, KIND OF BUSINESS OR INDUST			12. CITIZEN OF WHAT CO
	do	Housewife	Pennsylvani		U.S.A.
	V3.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	a	0.0.8.
	)	111.77 t D			
	15	WILLIAM Bryan WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17.	Harriet Grime	Address	
	(Ye	s, no, or unkown) (Ifyesgivewerordetesofservice) 214-09-4793			
70		NO -	Springfield H	ospital Rec	
		18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c).]			ONSET AND DE
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure			Month
		590X DUE TO			
		Conditions, if eny, which \ (b) Acute and chron	ic membritis.		Days and
- 12		geve rise to immediate cause		TAN SAME TO SEE	03 0
		(e), stelling the underlying			
	7	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N	OT BELATED TO THE TERMINAL DISE	ASE CONDITION GIVEN	IN PART I(a) I 10 WAS ALL
	CERTIFICATION	PARI II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO BEATH BOTT	OT KEENTED TO THE TERMINAL DISE	ASE CONDITION GIVEN	PERFOR
	CA	Chronic brain syndrome, senile brain	disease,		YES N
56	RTIE	206. ACCIDENT WAS UNDERLYING   206. DESCRIBE HOW INJURY OCCURED OR CONTRIBUTING   CAUSE OF DEATH	D. (Enter neture of injury in Pert I or I	Pert II of item 18.)	
1		(IF EITHER, NOTIFY MEDICAL EXAMINER)			
	₹ S		ACE OF INJURY (Home, ferm, 20f.	(City or town)	(County) (S
	MEDI	Hour e.m. While Not While et work et work et work	tiory, street, office bidg., etc.)		
			6-20 1067	10 7-13	- 10 67 show (1) (w
		21. 1 certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7-13-19.61, and that	8.00.8	· M ·	m, 17.822, Indi (I) (v
			death occured ap.e.v.w.,	from the causes an	on the date stated
		22a SIGNATURE	ATTENDING MED.	STAFF	
			A.D. PHYS. DIRECTOR	PHYS.	7-]
		22c, PHY ICIAN'S NAME (Type)	22d. ADDRESS		
	-	Agustin del Campo, M.D.	Springfield H		
1000		BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY 23d.	LOCATION (City, town	or county) (Ste
		REMOVAL (Specify)	( mathe 1 kg	100 O.EL . 77	
		Burin July 15, 1961 Kose Itill	CEMETERY 17	" ICC TO	0 45.44 . 13
0		Buring July 15, 1961 Rose Hill FUNERAL DIRECTOR'S SIGNATURE ADDRESS		EGISTRAR 256. REGIST	RAR'S SIGNATURE
2				EGISTRAR 25b. REGIST	RAR'S SIGNATURE

no paintened to the heat grade to Figure 1 at E. Stattler 1981 Lates one of out of AT 1882 , 32 graduation and a second 7 1 2 m 10 m 1 1 C CONTRACT LEVELOUE LANGUESTING . nittanten presunt bez editon -Commonly by in produces, sent to brothe disease. To the Control Constra del Compo. E ... ... By antibuties . introcol oferfourted .t.h.on\_20166 nefough N Box int let 15, 1967 Part 1871 Comment of 1988 Electrical Williams Rest His contract Comment Histories

OR STA	TE	779MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.	07784
ALTH D	EPT.	1. PLACE OF DEATH  a. COUNTY  MARYLAND  2. USUAL RESIDENCE (Where deceosed lived. If institution; Residence before o. STATE  b. COUNTY	odmission)
of Health	VI	b. CITY OR TOWN (If outside corporate limits, write RURAL ond give near and give frequent lown)  C. CITY OR TOWN (If outside corporate limits, write RURAL and give near and give frequent lown)  A 111110000000000000000000000000000000	rest town)
Soor		d. NAME OF HOSPITAL OR INSTITUTION Attends in hospital, give street address)  d. STREET ADDRESS  1533 Byld St.	ON A FARM? YES NO
he Stat		3. NAME OF DECEASED (Type or print) SIE H First AND TEELE SOF DEATH DOY	Yeor 19 6 1
2 with 1	T	WIDOWED DIVORCED 77 75.	F UNDER 24 HRS Hours Min.
Poge Poge I ond hin 72 h		10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote 6) foreign-country)	WHAT COUNTRY
poges ent with		13. FATHER'S NAME LAWRENCE 14. MOTHER'S MAIDEN NAME	
it. File		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (You, no, or unings) (If yes, give wor or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT	
niner's Office along a burial-transit person, or removal, and i	/	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  DUE TO  Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost.  (c)	IL BETWEEN AND DEATH
used as		<del>                                    </del>	WAS AUTOPSY PERFORMED? S NO
ould be	0	20a. EXTERNAL CAUSE WAS PRIMARY Dor CONTRIBUTING D  CAUSE OF DEATH.  20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)  Attempting to swim from an island in the lake and failed to make shore.	
he Chie ge 3 sho ior to b	06	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)  Not white Not white of work of work of work and work are compared to the com	(Stote) Md.
forworded to to DIRECTOR: Pa	2	SIGNATURE M.D. CHIEF MEDICAL EXAMINER	ond in my
NERAL NERAL 's design		EXAMINER'S NO. G.LENN SPELCHER GENERATION 1226. DATE THEREOF. 1220. NAME OF CEMETERY OF CREMETERY OF CREMETER	154.4.1
10 FU	2	220. BURIAL CORMATION, 12b. DATE THEREOF, 12c. NAME OF CEMETERY OR COMMATON 22d. LOCATION (City, 10km, or county)  23. JUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE  24b. REGISTRAR'S SIGNATURE	(Stote)
15ME 2/57	Of.	Miller - 130 6. Felt les , DATEIN 5 '61 O.T. 9 K	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO THE STATE OF DEATH.	
L Research Victor (1994)	

7794 CERTIFICATE OF DEATH Reg. Dist. No. with director PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY filed b. COUNTY MARYLAND unerol b, CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) be RURAL and give nearest town) P d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OV YES NO NAME OF First Middle 4. DATE Last Month Day Year DECEASED GEORGE (Type or print) DEATH 196 E 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years last bythdoy) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours DIVORCED [ WIDOWED 100. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) corbon ofter 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME CHARLES move hours IS. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) HOURS DUE TO NFARCTIONSSHOCK Conditions, if any, which gave rise to immediate DUE TO cotse (a), stating the under-DSCLEROTIC CARDIOVASCULAR DIS lying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour o. m While Not while at work at work 21. I certify that I attended the deceased fram 19.61 that I last saw the deceased and that death accurred at 1 M, fram the causes and an the date stated above. ADDRESS (Street, city or town, stote) ACTUAL DIREC SIGNATURE P should PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) poge REMOVAL (Specify) 10 **FUNERAL DIRECTOR'S SIGNATURE** ADDRESS 46. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS A15 (4) JUL 1 8 '6 arthur S. France 15M 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

A CALL TO A CALL OF THE SECOND AND A CALL OF THE SECOND AND ADDRESS AND ADDRES	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7795

07786

		PLACE OF DEATH				2.	USUAL RESIDE	NCE (Who	ere deceased	l lived. If institu		e before adm	ission)
	C	o. COUNTI	Carroll		MARYLA	ND	o. STATE	rvla	and	b. COUNT	Car	rroll	
	E	RURAL ond give ne		c. LENGTH OF STAY IN	11Ь	7	100		rote limits, write	RURAL ond g	ive nearest to	wn)	
		Rural - V	Vestminst	er	11.				Vestm	inster		10.00	FOIDENIGE
			AL (If not in hospitol, (	ive street	oddress)		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?						
1			v Road, R	. D.	# 6	B	ird Vi	ew F	Rd. R	. D. #	6	YES	□ NO 🔟
1		NAME OF DECEASED (Type or print)	Fin	st	Middle	O.T.	Last		4. DATE OF DEATH		onth	Day	Yeor
			JOHN	-		-	LROY		DEATH	July	28,	VEAD IF III	19 67
	5. S	SEX	6. COLOR OR RACE	7. MARI	RIED NEVER MARRIED	□ B. D	ATE OF BIRTH			9. AGE (In year lost birthday		Days Hou	
		Male	White	WIDOW		F	eb. 20	, 18	381	80 yr	<b>'</b> \$.		
	10a.	during most of work	DN (Give kind of work ling life, even if retired	done 10b.	KIND OF BUSINESS OR	INDUSTRY	11. BIRTHPLA	CE (Stote o	or foreign co	ountry)	12.CITI2	ZEN OF WHA	COUNTRY?
-		Stone Mas	son				Maryl	The state of the s			U.	S.	A .
1	13.	FATHER'S NAME				1	4. MOTHER'S A	AAIDEN N	AME				
	)	Owen	Gilroy				U	nkno	wn				
1			R IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17. INFO	RMANT			A	ddress		
			it yes, give was as dates of	a.v.ca,		Mrs	. Gert	rude	Bar	nard,	Same a	as 2	
		18. CAUSE OF DEA	TH [Enter only one co	use per, li	ine for (o), (b), and (c).]				-	1.		INTERVAL	BETWEEN
		PART I. DEA	TH WAS CAUSED BY:	Ca	rower 1	Eleman	Loves	rai	ricu	les Lel	rellate	ONSET AN	ID DEATH
		115	DUE TO		2			1		1		193	59
		Constitution of the	934	RAI	Con a C. La	he !	1.	hea.	Pur	16. 1		-40	
		Conditions, if or	mmediate	المال	·		enery"			ical	new	10	
		couse (o), stoting lying couse lost.	the under DUE TO	Gal	legior been	- C		.1	ed	eecha		196	
	z		J (C	IDITIONS	CONTRIBUTING TO DEAT	U BI TINO	T DELATED TO	ME TERMI	NIAL DICEAC	E CONDITION C	CIVENI INI DADI	1(o) 19. WA	S AUTOPSY
	110	FARI II. OIF	IER SIGNIFICANT CON	DITIONS	CONTRIBUTING TO DEAT	H BOOMNO	I KELATED TODA	ITETEKMI	NAL DISEAS	E CONDITION C	SIVEN IN PAKI	PER	FORMED?
	CA											YES	_ NO _
	CERTIFICATION	20a. ACCIDENT WA OR CONTRIBUTING	CAUSE OF DEATH	20b. DES	CRIBE HOW INJURY OCC	URRED. (E	nter noture of	injury in P	Port I or Port	t II of item 1B.)			
			MEDICAL EXAMINER)			111111							
	MEDICAL	20c. TIME OF INJUR	Y Month, Doy, Ye				OF INJURY (He, street, office I			or town)	(C	county)	(Stote)
	WED	Hour o.m.	19	While of wor		.00.01)	, sircoi, onico i	Diag., etc.	1				
			. 415 401 2 1 2 2	1			195	3	V. U.	28 km	1 .06	1	
			7 (		ded the deceased fr			19.	- Address		/	_, that (1)	
			ed alive an o	- Just	196/ , and th	hat dea	th accurred	0640	M, fram	the causes	find an the	date state	
		220. SIGNATURE	1/	1 0	I an con		ATTENDING	ME	- D	STAFF			22b, DATE SIGNED
		X	Howard	-6	Hell	M.D	. PHYS.	DIE	RECTOR [	PHYS.		28	10,6
		22c. PHYSICIAN'S NAME (Type)					22d. ADDRES	S				6	
			Howard E	. На	11. M. D.	90	Syk	esvi	lle	Mary	land		
	230.	BURIAL, CREMATIO		)F	23c. NAME OF CEMET	ERY OR C	REMATORY		23d. LOCA	TION (City, town	n, or county)	(S	tote)
		REMOVAL (Specify)	7-30-19	61	Brandenb	170	Comete	77.77	Carr	011 Co	. Ma	rvlan	7
	24.	FUNERAL DIRECTOR			ADDRESS	5			BY REGIST		GISTRAR'S SIG		
	1	C. M. Wa	Ita Win	fie]	ld. Marvl	and		DATE J			arthur S.		
0	_	O. M.S.	TOTA WITT	7767	rug Platy 1	autu		-1112 91	N. Sp.				

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HIASOSO STADISHTHED STATE BEST THE RESERVE OF THE PROPERTY OF THE PROPER the committee of the co CANTON DECEMBER OF THE PARTY OF THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER. thenthy and the three of the section of the section

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 7796 CERTIFICATE OF DEATH funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before a. COUNTY b. COUNTY by the and 2 death. Carroll Balto, City MARYLAND Maryland b. CITY OR TOWN (if oulside corporata limits, c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If oulside corporale limits, write RURAL and give neerast town) write RURAL end give neerest town) Sykesville Baltimore 13 Trea me d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO Y Springfield State Hospital 1139 Homestead Street 3. NAME OF 4. DATE DECEASED Griffin (Type or print) Louise DEATH Marv 19 67 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Devs Hours Female White WIDOWED T December 23, 1869 DIVORCED 10a. USUAL OCCUPATION (Giva kind of work 12. CITIZEN OF WHAT COUNTRY 10b. KIND OF BUSINESS OR INDUSTRY | III. BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) Housewife U.S.A. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Milway Sarah Ann 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyas give wer or detes of service) No Springfield Hospital Records 18. CAUSE OF DEATH [Entar only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED 8Y: Septic embolism with gangrene of left leg. days IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which (b) geve rise to Immediata cause DUE TO (a), steting the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) | 19, WAS AUTOPSY C.B.S. associated with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction. PERFORMED? NO TH 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Part II of item 18.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 1 20f. (City or town) (State) factory, street, office bldg., etc.) While Not While at work et work p.m 7/22/6]....., 19....., that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from ... 5. saw the deceased alive on.....7/22...............19.61..., and that death occured a 2.22 M. from the causes and on the date stated above. 222 SIGNATURE ATTENDING SIGNED DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Julian Radzykewycz, M.D. Springfield Hospital, Sykesville, Md. director, 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOXAL (Specify) 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) DATE JUL 2 6 '61 15M 9/60 Certhur S. Thous

MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7797 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) a. COUNTY b. COUNTY by the fand 2 s death. Carroll Balto. City MARYLAND Maryland b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) write RURAL end give neerest town) Baltimore Svkesville 19 vrs 3 mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d STREET ADDRESS a. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO TO Hanover Street 4. DATE Middle Month Year DECEASED (Typa or print) Jeanette DEATH 61 Grosh July 19 and cor 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 24 HRS. 9. AGE (In yeers | IF UNDER 1 YEAR last birthday) Hours Female WIDOWED DIVORCED I March 1. 1900 remove 10e. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & Steta, or foreign country) done during most of working life, even if retired) U.S.A. None Marvland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME guipu Charles Grosh Mary Jane Woodside 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unknwn) | (If yes give wer or detes of service) Springfield Hospital Records INTERVAL BETWEEN 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Septicemia Davs IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which Unk geve rise to Immediate causa DUE TO (a), stelling the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY PERFORMED? Psychosis with convulsive disorder, epileptic deterioration. 20s. ACCIDENT WAS UNDERLYING | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Part II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, ferm. (County) (Stata) fectory, street, office bldg., etc.) While Not While et work et work 21. I certify that (I) (this hospital) attended the deceased from 4-24-, 1942, to 7-24-, 1961, that (I) (we) last saw the deceased alive on 7-24- 19 61, and that death occurred at 0:50 from the causes and on the date stated above. SIGNATURE 22b. DATE ATTENDING 7-24-61 SIGNED DIRECTOR T PHYS. FUNERAL 22d. ADDRESS 226 PHYSICIAN'S NAME (Type) Springfield Hospital, Sykesville, Md. Julian Radzykewycz, M.D. ector, 230. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) ÷ 5.8 10g 25a. REC'D BY REGISTRAR 25b. 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 9/60

within 24 hours after

MARYLAND STATE DEPARTMENT OF HEALTH

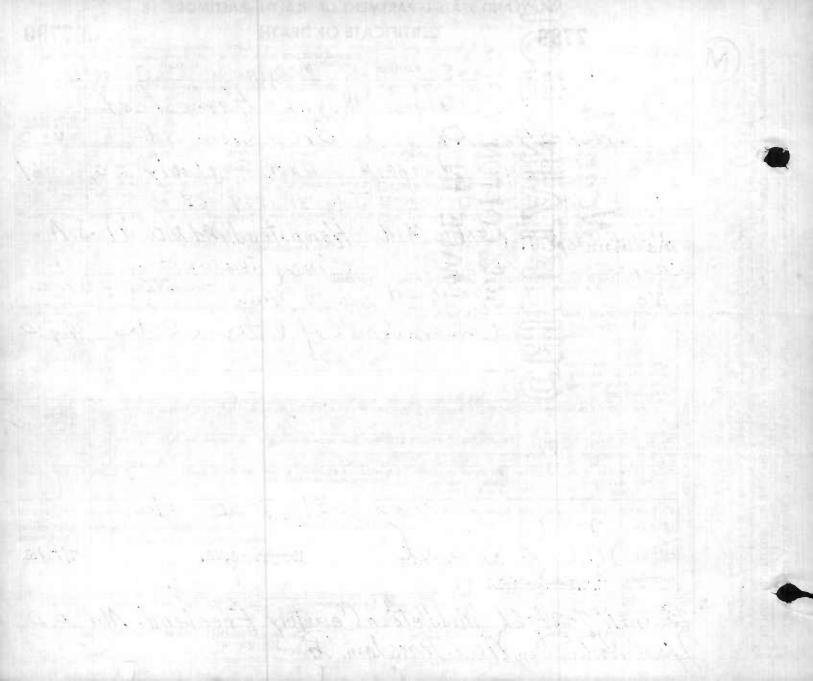
200 88770 cala .o. file 19 5 T 3 56. Law Icholl w Jart Alany in a Actor of confident .cold to lead a bound in . talmorth avietnman differ to fer the D-ALLA May refine water Hart William Comment Comment of the Toronson of a located for the season in of

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH Reg. Dist. No. director, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o COUNTY filed b. COUNTY MARYLAND funeral o b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corperate limits, write RURAL and give nearest town) RURAL and give nearest town) shauld NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? 50 YES NO 4. DATE OF DEATH 3. NAME OF -Middle Day Yeor DECEASED fille (Type or print) Pages 5. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 8. DATE OF BIRTH MARRIED NEVER MARRIED campletely lost birthdoy) Months Dovs DIVORCED | WIDOWED | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during-most of working life, even if retired) puo MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT attending -505 0 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o DUE TO Conditions, if ony, which gned gove rise to immediate DUE TO couse (o), stoting the underbeen si ar attending physician. pup lying couse lost. burial-transit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO TO 20g. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) certificate (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month. Doy, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) Hour o. m. While Not while ot work ot work detoched for 21. I certify that I attended the deceased fram. that I last saw the deceased and that death accurred at 413 \_M, fram the causes and an the date stated above. may be Vetained by the TO FUNERAL DIRECTOR: ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL pe priar Hampstead Md. AL OR SIGNATURE page 3 shauld PHYSICIAN'S M. C. Porterfield NAME (Type) 220 BURIAL, CREMATION, 226. DATE THEREOF 22d. LOCATION (City, town, or county) NAME OF CEMPTERY OR CREMATORY (Stote) REMOVAL (Specify FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE VS A15 (4) arthur S. Kraus 15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



urs ofter death. Page 4

LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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6000	CERTIFICA	IE OF DEATH	Uddai
1. PLACE OF DEATH a. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution on STATE b. COUNTY	an: Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RI	URAL ond give nearest town)
d. NAME OF HOSPITAL (If not in haspital, give stree OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
Henryton State Hospit	al	1704 Rutland Avenue	YES NO
3. NAME OF First DECEASED (Type or print) Lillian	Middle	Last 4. DATE Mon OF DEATH Ju	
5. SEX 6. COLOR OR RACE 7. MAI	RRIED NEVER MARRIED	B. DATE OF BIRTH 9-15 9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 H
Female Negro WIDOV	WED DIVORCED	?-?-1896 64-yrs.	Months Days Haurs Min
10a. USUAL OCCUPATION (Give kind af work done 10t during mast of warking life, even if retired)  Housewife	b. KIND OF BUSINESS OR INDU	Littleton, N. C.	12. CITIZEN OF WHAT COUNTE
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	Til Latte de la late
Louis Massey		Marie McLean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 1(Yes, no, or unknown) (If yes, give war or dates of service)		NFORMANT Addr ecelia McKoy-Daughter 320	
Canditions, if ony, which gave rise to immediate cause (a), stating the under-lying couse last.			
САЛІС	S CONTRIBUTING TO DEATH BUT	I NOT RELATED TO THE TERMINAL DISEASE CONDITION GIV	/EN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	SCRIBE HOW INJURY OCCURRE	ED. (Enter noture of injury in Part I or Part II of item 18.)	
Hour a.m. 19 While the world with th	le Not while fo	ACE OF INJURY (Hame, farm, 20f. (City or town) ctory, street, office bldg., etc.)	(County) (Sto
21. I certify that (I) (this hospital) after sow the deceased alive on July 6	nded the deceased from 19 61, and that	deoth occurred atM, from the causes on	
22a. SIGNATURE M.	Main lang Mi	ATTENDING MED. STAFF PHYS.	22b. DATE SIGN
22c. PHYSICIAN'S NAME (Type) Edgars M. Mac	culans, M. D.	Henryton State Hosp.,	Henryton, Md.
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)	23c. NAME OF CEMETERY CO	METERY HANNELL TO	or county) (Stote)  CO M.C.  STRAR'S SIGNATURE
R. J. C. OLLICIT!	9 12 Epresolo	21 ST DATE JUL 12'61 cin	thus S. Krane

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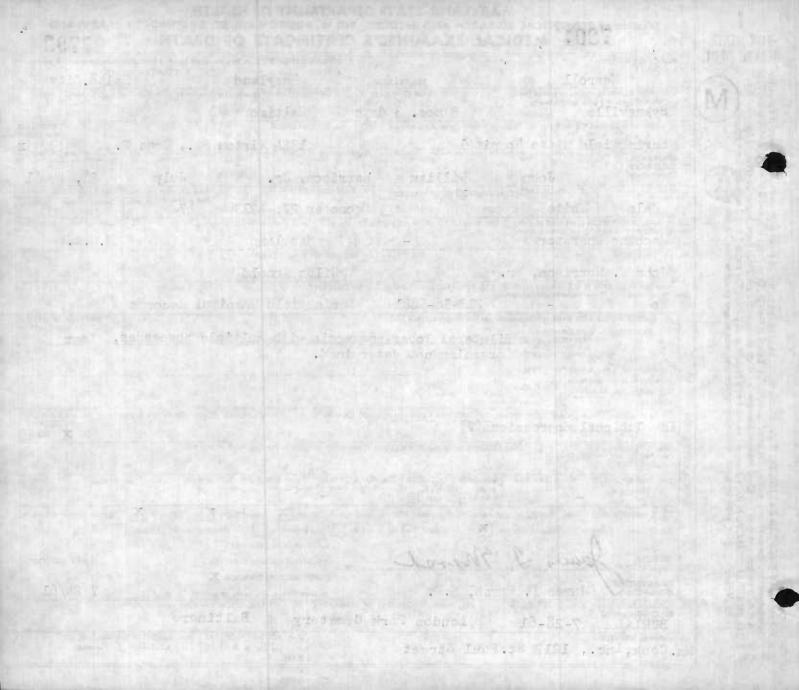
# FOR STATE HEALTH DEPT. TO DEXUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fameral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after Neath.

VS. A15ME 5M 7/59

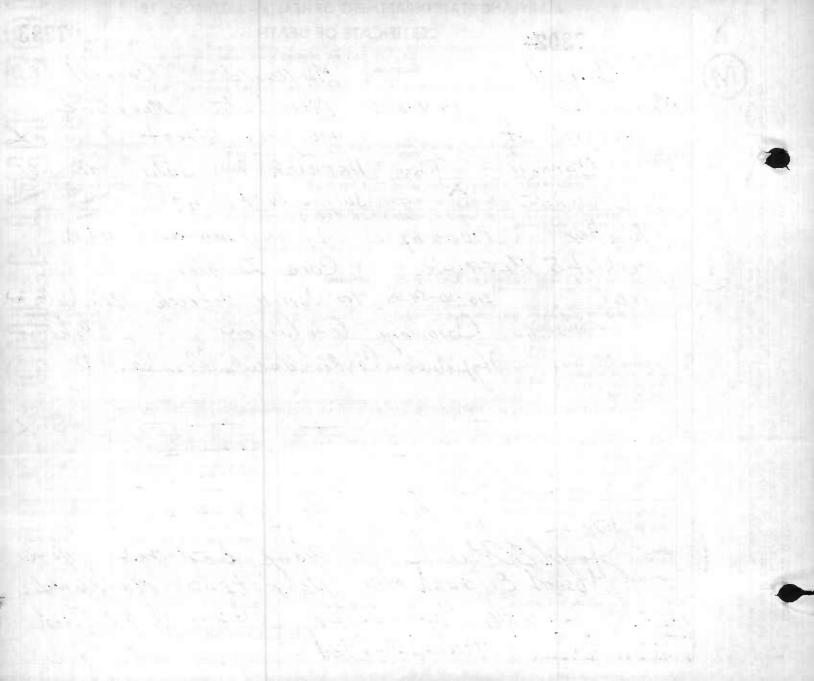
# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07792

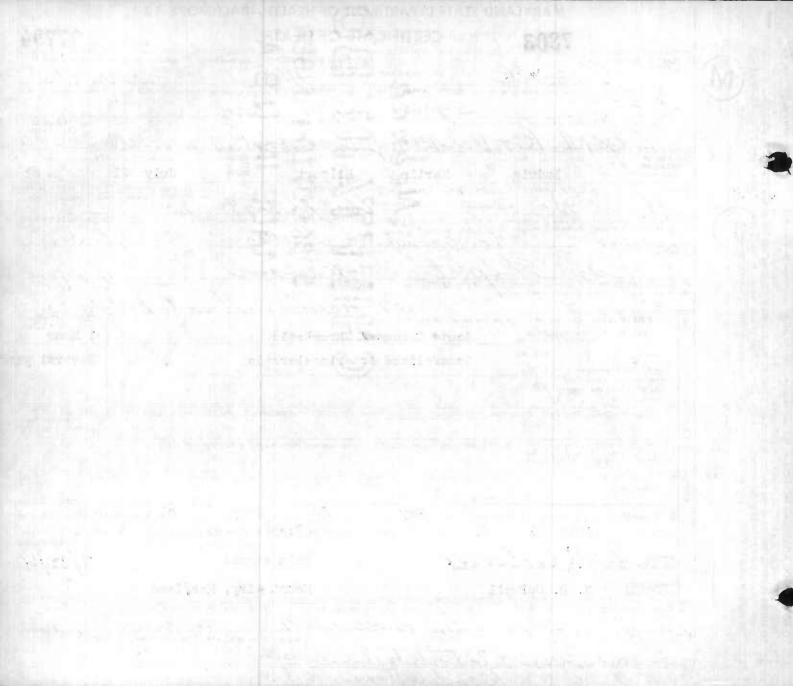
1.	PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE			lance bafore admission)
	Carroll		MARYLAND	a. STATE Maryla	and b. coul	Balt	o.City
Y	b. CITY OR TOWN (if outside con		c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If ou	itside corporata limits, writ	e RURAL and giv	va nearast town)
1	Sykesville	town}	3 mos. 3 day	s Baltimo	re #2	VO	1-4
	d. NAME OF HOSPITAL OR INST	ITUTION (if not in h		d. STREET ADDRESS	"		. IS RESIDENCE
	Springfield St	ate Hospi	tal	1324 Wi	rton St., Z	one 2.	YES NO
3.	NAME OF DECEASED	First	Middle	Last 4.	DATE Mont	th De	y Year
		John	William H	arrison, Jr.	DEATH July	9	24, 19 61
5.	. SEX 6. COLOR	OR RACE 7. MARI	RIED X NEVER MARRIED 3	DATE OF BIRTH	9. AGE (In years last birthday)		
	Male Whit	e widov	VED DIVORCED D	ecember 27, 19	)13   47 <sub>yrs</sub> .		
	a. USUAL OCCUPATION (Giva king on a during most of working lifa, av		KIND OF BUSINESS OR INDUSTR	Y 11. BIRTHPLACE (State or f	oreign country)	12. CITIZEN	OF WHAT COUNTRY
	Machine Operat		-	Maryland	1	U.	S.A.
13	. FATHER'S NAME			14. MOTHER'S MAIDEN NA	ME		
	John W. Harris	on, Sr.		Hilda Arnol	d		
	. WAS DECEASED EVER IN U.S. A		6. SOCIAL SECURITY NO. 17.	NFORMANT	Addres	is	
(1	(es, no, or unkown) (Ifyesgiveward	or delas of service;	213-16-5881	Springfield H	lospital Rece	ords	
=	18. CAUSE OF DEATH [Enta	r only one cause pe	r lina for (a), (b), end (c).]	1 0		11	INTERVAL BETWEEN
	PART I. DEATH WAS CAU	SED BY: Rils	ateral lobar pne	umonia with m	oltinle abso	esses.	Davs
	L GENERALE		ganism not deter			-	20,5
	Conditions, if any, which		Sauram non de ser	. HLLIGO.		10.77	
1	gave risa to immadiata cause	(b)					
	(a), steting the undarlying	DUE TO				343 17	
	causa lest.	(c)					
CERTIFICATION	Involutional de		ONTRIBUTING TO DEATH BUT NO	I KELATED TO THE TERMINAL	DISEASE CONDITION GI	VEN IN PART T(a)	PERFORMED?
HE	2De. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING		CRIBE HOW INJURY OCCURED. (E	intar nature of Injury in Part I o	r Part II of Item 18.)		
15	CAUSE OF DEATH.						
MEDICAL	20c. TIME OF INJURY Month	Wh		CE OF INJURY (Homa, farm, ory, street, office bldg., etc.)	20f. (City or town)	(County)	(Steta)
	21. I certify that I took	charge of the re	emains described above, he	ld an Autopsy 🔼 Ins	pection K, Inqui	iry X, ar	nd in my opinion
	death resulted from: N	atural causes	Accident , Suic	ide , Homicide	, Undetermined n	nanner	
	1			CHIEF MEDICAL EXA	MINER		
	ACTUAL SIGNATURE	6 J. 7	Moral	M.D. ASSISTANT MEDICA	L EXAMINER		DATE SIGNED
	EXAMINERS Jame	s T. Mars	sh, M.D.	DEPUTY MEDICAL EX Address (Street, city,	Land		7/24/61
22	a. BURIAL, CREMATION, 22b. D.	ATE THEREOF	22c. NAME OF CEMETERY OF	CREMATORY 220	d. LOCATION (City, town	n, or country)	(State)
	BURIAL 7-2	8-61	Loudon Park	Cemetery	Baltimore		
	3. FUNERAL DIRECTOR		ADDRESS	24e. REC'D E	2 6 6 REC	GISTRAR'S SIGN	TURE
W	m.Cook, Inc., 12	217 St. Pa	aul Street	DATE	2001	winn S. Ti	route .
				7 -7115			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 7802 Reg. Dist. No. director Page PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND funeral b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 OR TOWN (If outside corporale limits, write RURAL and give nearest town) UKAL and give nearest town) should ANCheston the d. NAME OF HOSPITAL (If not in hospital, give street address) STREET ADDRESS IS RESIDENCE OR INSTITUTION ON A FARM? by 12 YES NO and 4. DATE NAME OF First Middle Month Day Year filled DECEASED OF (Type or print) DEATH Pages 196 IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years campletely lost birthday) Months Days Haurs DIVORCED | WIDOWED [ papers. 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) BIRTHPLACE (State 12. CITIZEN OF WHAT COUNTRY? death pup carban after 13. FATHER'S NAME 14. MOTHER'S MAIDEN MAME physician remave WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT 216-10-5436 attending please INTERVAL PETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c). PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (o) the **DUE TO** þ permit. any Conditions, if any, which gned gove rise to immediate DUE TO couse (o), stating the under pub lying couse last burial-transit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) [19. WAS AUTOPSY PERFORMED? has YES | NO 20a. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II af item 18.) OR CONTRIBUTING LI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or tawn) (County) (State) foctory, street, office bldg., etc.) Haur a. m. While Nat while at wark at work 21. I certify that, attended the deceased from 19 182 that I last sow the deceosed detached that deoth occurred at 10 A alive on \_M, from the causes and on the date stoted obove. and FUNERAL DIRECTOR: ADDRESS (Street, city or ACTUAL pe AL OR retained prior SIGNATURE 3 should PHYSICIAN NAME (Type 220. BURIAL CREMATION, 22b. DATE THEREOF LOCATION (City, towns or county MAME OF CEMETERY OR CREMATORY (Stote) page (Specify) 0 23-EUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE **ADDRESS** 24a. REC'D 8Y REGISTRAR VS A15 (4) 5 '61 15M 9/58



		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18	0 W W 0
		7803 CERTIFICATE OF DEATH Reg. Di	st. No. 0779
1	1. P	PLACE OF DEATH 2. COUNTY  2. USUAL RESIDENCE (Where deceased lived. If institution: Residen 3. STATE  4. COUNTY  5. COUNTY  6. COUNTY	ce befare admissian)
	-	D. CITY OR TOWN (If outside corporate limits, write   c. LENGTH OF STAY IN 1b   c. CITY OR TOWN (If outside corporate limits, write RURAL and	roll
		RIRAL and give neagest town 5 4rs Miles Christian 5 4rs	give nearest town)
	-	d. NAME OF HOSPITAL (What in haspital, give street address) OR INSTRIPTION  d. STREET ADDRESS	e. IS RESIDENCE
1		Ridge Kd. R. J. D. 2 Mt. airy Ridge Fd, R. J. D. 2 Mt	ary YES NO
		NAME OF First Middle Ost OF Month	(pay Year
5	_	Type or print)  Ludwig Martin / Hilfert DEATH July 2]  EX.   6. COLOR OR RACE   7. MARRIED   B. DATE OF BIRTH   9. AGE (In years   FUNDER	19 6.
		M. WIDOWED DIVORCED   Man 26 1898   lost birthday) Manths	Days Haurs Mir
	10a.	USUAL OCCUPATION (Give kind of work done 10b-KIND OF BUSINESS OF INDUSTRY 1) BIRTHPLACE (State or foreign country) 12.CITI	ZEN OF WHAT COUNT
		mararer Co. Ownday Latto.	1. S. a
	13.	FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
	16	WAS DECEASED EVER IN U. S. ARMED FORCES? 6. SOCIAL SECURITY NO. INFORMANT Address	07.17
	Yes,	(If yes, give war ar dates of service)	lag Di
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Acute Coronary Thrombosis	1 hour
		Generalized Arteriosclerosis	Several
		Canditians, if any, which (b)	Dovoral
		cause (a), stating the <u>under-</u> lying cause last.	
	NO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	T 1(a) 19. WAS AUTOP
	ICATION		YES NO
	CERTIFI	20a. ACCIDENT WAS UNDERLYING  CAUSE OF DEATH  OR CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
	3	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, 20f. (City ar tawn)	Caunty) (St
	MEDI	Haur a. m.  While Nat while p. m.  19 at wark at wark at wark	
		21. I certify that I attended the deceased fram May 1958, to July 1, that I lo	st saw the decea
		alive an July 21 , 1961 , and that death accurred at 7:25 PM, from the causes and an the	date stated abo
		ACTUAL LIER ( Level) Main Street, city or town, state)	DATE SIG
		SIGNATURE WELL CULLURED M.D. Main Street	1/22/4
		PHYSICIAN'S NAME (Type) W. B. Culwell Mount Airy, Maryland	
	22a.	BURIAL CREMATION, 22b. DATE THEREOF 22c, NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City town, or county)	(State)
	6	Sural Specify 7/24/61 Lakeniew Monarial th Conroll	Co Me
	23.	FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  ADDRESS  ADDRESS  DATE MI 2 6 '61  ADDRESS  DATE MI 2 6 '61	



by the funeral director, I 2 should be filed with

certificate has been signed by the attending physicion and completely fille

ATTENDING PHYSICIAN: The low requires that the death certificate be

event, within 72 haurs after death

remaval,

os the burial-transit to burial, crematian,

page 3 should be detache the State Board of Health

rs ofter death. Page 4

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07795

_												
	PLACE OF DEATH a. COUNTY	Carroll	W.		MARYL	AND	2. USUAL RESIDENCE (Whe		d lived. If institution b. COUNTY	n: Residence be		/
	b. CITY OR TOWN ( RURAL and give a Sykesvi		s, write	c. LENG	LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and giver 4 mos 25 days Ellicott City						earest town)	2
d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Springfield State Hospital							d. STREET ADDRESS	t Ave			e. IS RESIDEN ON A FAR YES NO	
	NAME OF DECEASED (Type or print)	Firs Ka <b>ti</b>	100	ouise	Middle Richa	ards	on Hobson	4. DATE OF DEATH	Monti Ju:		Oay Year 196	-
\$.	Female		7. MARR WIDOWE	_	EVER MARRIED DIVORCED		September 7,	1874	9. AGE (In years tost birthday) 86 85 yrs.	Months Doys	Hours A	HRS Min.
10c		ON (Give kind of work d king life, even if retired)	one 10b.	KIND OF	BUSINESS OR	INDUS	TRY 11. BIRTHPLACE (Stote of Maryland		country)		S.A.	JTRY
13.	Joshua R	ichardson					14. MOTHER'S MAIDEN N					
	WAS DECEASED EVE ss, no, or unknown) No	ER IN U. S. ARMED FORC (If yes, give war or dates of se		SOCIAL SI	ECURITY NO.		FORMANT Springfield H	lospit	Addres			
	111	ATH [Enter only one cau ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO	_		(b), ond (c).]	oni	9.				TERVAL BETWE NSET AND DEA days	
	Canditions, if a gave rise to couse (a), stating lying cause last.	the under-										
CATION	C.B.S.as	RESTEATE ON COR	ester.	CONTRIBA.	H dise	Se	with Biythick	O TEAS	CCI ON GIVE	EN IN PART 1(a)	19. WAS AUTO PERFORME YES NO	OPSY D? O
L CERTIFI	OR CONTRIBUTING	AS UNDERLYING  G CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HO	W INJURY OC	CURRED	D. (Enter nature of injury in P	ort I ar Par	rt II af item 1B.)			
d	00 71117 07 11111						CE OF WHITEH HE	005 161			1 4	

Not while of work

20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.)

61, that (1) (we) last

21. I certify that (I) (this hospital) attended the deceased fram saw the deceased alive an

ased fram. Feb. 11, 19.60, to 7-6-, 19.61, that (I) (we) last and that death accurred at 2:30m, from the causes and an the date stated above.

ATTENDING PHYS. M.D. 22d. ADDRESS MED.

Springfield Hospital, Sykesville, Md.

22b. DATE

Ac. PHYSICIAN'S NAMB (Type) 23a. BURIAL, CREMATION.

REMOVAL (Specify)

23b. DATE THEREOF

Agustin delCampo, M.D.

7204

23c. NAME OF CEMETERY OR CREMATORY Good Shepherd

23d. LOCATION (City, town, or county)

7-6-

(State)

FUMERAL DIRECTOR'S SIGNATURE

ADDRESS

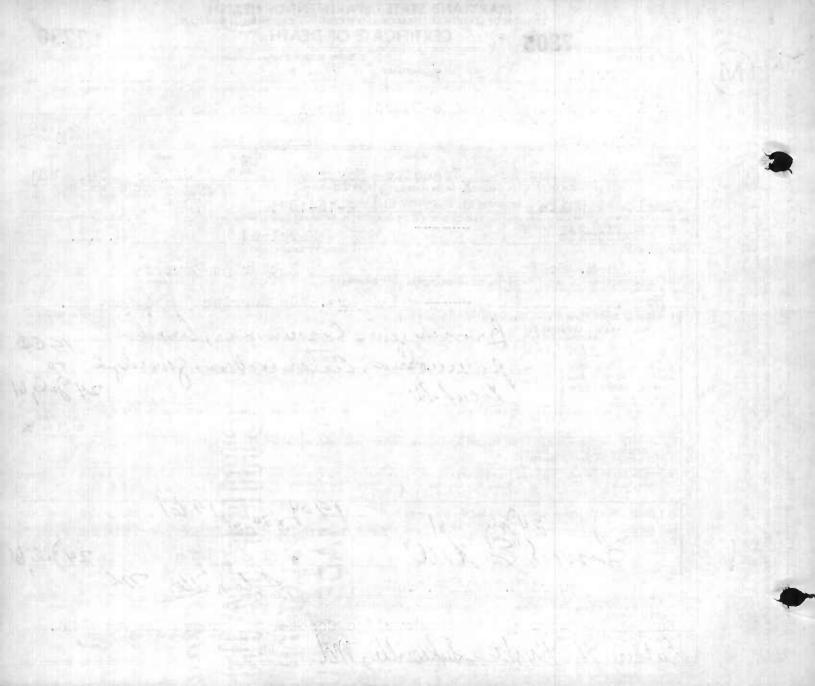
250. REC'D BY REGISTRAR DATE JUL 1 0 '61

25b. REGISTRAR'S SIGNATURE

may be retained by the TO FUNERAL DIRECTOR:

· Walter IS  MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

	7805		CERTIFI	CATE	OF DEATH				077	96
1. PLACE OF DEATH o. COUNTY Carr	oll		MARYL		usual residence (wo. state		l lived. If institut b. COUNTY		efore admis	sion)
b. CITY OR TOWN (If a RURAL and give nea		its, write	LENGTH OF STAY II		c. CITY OR TOWN (IF		rate limits, write F	RURAL ond give	nearest tow	n)
Rural Wo	odbine		Mine Yes	rs	Rural	Woodb	ine			
d. NAME OF HOSPITA OR INSTITUTION Morgan	73 7	give street ad	dress)		d. STREET ADDRESS	n Roa	d		ON	SIDENCE A FARM?
3. NAME OF		rst	Middle		Last	4. DATE	Moi	nth	Day	Year
(Type or print)	Bess	sie	Jeanett	e H	loyer	DEATH	J1177	7	Oli	1961
S. SEX		and the same of	NEVER MARRIED		ATE OF BIRTH		9. AGE (In years	Y	AR IF UND	
Female	I Toi to	WIDOWED			0 16 1901		last birthday)	Months Day	/s Hours	Min.
10g. LISUAL OCCUPATION	(Give kind of work	done 10h KI		_	11. BIRTHPLACE (State	or fareign co	/ \		OF WHAT	COUNTRY
during most of workin	ng life, even if retired	1)			7.5				S.A.	
13. FATHER'S NAME	MITTO			11	4. MOTHER'S MAIDEN			0.1	J. H.	
	0 0-31						7			
	S. Sedic		5111 555115151111	1.7 1150	Kat	herin	e Bower			
15. WAS DECEASED EVER (Yes, no, or unknown) (If	yes, give wor or dates of		OCIAL SECURITY NO.	17. INFO	RMANI		Add	iress		
No					Mrs. Ada	Burri	er Woo	odbine	Md.	
gave rise to im cause (a), stating the lying cause lost.  PART II. OTHE	ne under-	c) LL	Culture To DEA	TH BUT NO	OT RELATED TO THE TERM	MINAL DISEASI	CONDITION GI	VEN IN PART 1(c	PERF	ORMED?
20g. ACCIDENT WAS OR CONTRIBUTING E	UNDERLYING  CAUSE OF DEATH	20b. DESCR	IBE HOW INJURY OC	CURRED. (E	Enter nature af injury in	Part I ar Part	II of item 18.)		YES	NO [2
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Ye	20d. INJ While at wark	_ Not while	20e. PLACE factory	OF INJURY (Home, fari y, street, office bldg., et	m, 20f. (City	or town)	(Cour	nty)	(State
21. I certify that saw the decease	77 /	attende	//		1934 15 th accurred at 5	.40	19 G/ the causes ar		that (I) ate states	, , , , , , , ,
22a. SIGNATUR	oward	8	Hall?	M.D	ATTENDING A	AED.	STAFF PHYS.		24	SICHE
22c. PHYSICIAN'S NAME (Type)	Howard	Е. На	dl M.D.		22d. ADDRESS	ylor	ville,	me	,	,
23a. BURIAL, CREMATION REMOVAL (Specify)	7-27 (	OF 1	23c. NAME OF CEME		REMATORY		TON (City, town,	or county)	(Sto	
24. FUNERAL DIRECTOR'S	SIGNATURE HALL	shit	Sykesin	lle,		D BY REGIST	RAR 25b. REG	ISTRAR'S SIGN	TURE	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution; Residence before edmission) e. COUNTY b. COUNTY by the and 2 death. Carroll Maryland Balto. MARYLAND b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town write RURAL and give nearest town) Sykesville 1 yr. 3 dys. Kingsville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO Springfield State Hospital Box 451 3. NAME OF Middle 4. DATE Month DECEASED OF ded (Type or print) DEATH Clara Elizabeth Hurline July 24 19 61 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In yeers | IF UNDER 1 YEAR 8. DATE OF BIRTH IF UNDER 24 HRS. last birthdey) | Months Deys Hours Female White WIDOWED T DIVORCED T September 24, 1891 10s. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11, BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired U.S.A. H ousewife Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Andrew J. Meisner Mary K. Schmidt 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or detes of service) No Springfield Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c),] failure ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Arteriosclerotic heart disease with congestive Years IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which geve rise to immediate ceuse DUE TO (e), steting the underlying PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? associated with cerebral arteriosclerosis without qualifying NO K use prior phrase.

Zoe. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d, INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Dey, Year 20f. (City or town) (County) (Stete) factory, street, office bldg., etc.) Not While Hour e.m. While et work et work 21. I certify that (I) (this hospital) attended the deceased from 7-21- 1960, to 7-24- 1961 that (I) (we) last 22e. SIGNATURE ATTENDING SIGNE PHYS. PHYS. DIRECTOR death. Page 4 22d. ADDRESS 224. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D. Springfield Hospital, Sykesville, Md. 23e. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town or county) (Stete) REMOVAL (Specify) OH inclu 25e, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SHENATUR ADDRES! VR A15 (4) arthur & Kraus 15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

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1. PLACE OF DEATH o. COUNTY C	arroll		MARYLA		STATE Mary	here decease Land	d lived. If instituti b. COUNTY		nce befor		ion)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				V 16	b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)								
RuralSyke	llm. 10da	ys	Williamsport										
d. NAME OF HOSPIT OR INSTITUTION Springfield	State Hospitol,				d. STREET ADDRESS  30 W. Poto	mac St	treet				FARM?		
3. NAME OF DECEASED	Fi	rst	Middle		Lost	4. DATE OF	Mor	ith	Do	,	Yeor		
(Type or print)	Jane				tchinson	DEATH			33		1961		
S. SEX		7. MAR	RIED NEVER MARRIED		TE OF BIRTH		9. AGE (In years last birthdoy) yrs.	IF UNDER	Dovs Dovs	Hours	ER 24 HRS.		
female	white	WIDOW			/28/79	4 -1 -							
during most of work	king life, even if retired	done 10b.	KIND OF BUSINESS OR	/	11. BIRTHPLACE (Stote New York		ountry)	12. CIT	IZEN OF	USA	COUNTRY?		
13. FATHER'S NAME				14	MOTHER'S MAIDEN						7		
John Morr	is				Elizabeth	McDor	nald						
15. WAS DECEASED EVE	R IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17. INFOR				lress					
(Yes, no, or unknown)	to her fire and of doles of t			Sprin	gfield Hos	p. rac	cords	Syk	esvi	ille,	, Md.		
Conditions, if o gove rise to i couse (o), stating lying couse lost.	mmediate DUE TO	) ) :)	rteriosclero							year			
E CBS assoc			le brain dia	_					K1 1(0) 1	PERFO	NO		
20g. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)												
20c. TIME OF INJUR Hour o. m. p. m.	RY Month, Doy, Ye	While			OF INJURY (Home, for street, office bldg., et	rc.)	y or town)	(	(County)		(Stote)		
21. I certify the saw the decease 220. SIGNATURS 22c. PHYSICIAN'S NAME (Type)		1/31 ha	rether his		ATTENDING DATE OF ATTENDING DA	MED. DIRECTOR [] Dringfi	STAFF	nd an the	e date	stated	we) last d abave. b. DATE signed 31/6		
23a. BURIAL, CREMATIC PMOVAL (Specify)		DF 6/	23c. NAME OF CEMET	TERY OR CRI		Jues	TION (City, town,	new	- 7	Stol	2)		
24. FUNERAL DIRECTOR	s signature	\$ 6	Justies Ville	1, 9	MA DATE	AUG 3	to d	ISTRAR'S SI	6				

VR A1S (4) 1SM 9/59

TO HOS

7075 design of the second Control of the state of the sta Manual Close of the Control of the C 

R STATE TO DECUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. We delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Meidred for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Mesith or its designated agent, prior to burial, cremation, or removal, and in any event within 77 hour after death. VS. A15ME 5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STOTESTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 07800

=	PLACE OF DEATH				I a		112 1 11 12 12	P. 11 b. Co. a factorious			
	. COUNTY	Carroll				aryland	b. COUNTY	Residence before edmission) Balto.City			
-	b. CITY OR TOWN (if outside corporate limits, write RURAL and give negrest town)			MARYLAND c. LENGTH OF STAY IN 1b		a di la la manada					
				Lmos.23days	Balti	ta limits, writa RURAL an	3001-4				
	d. NAME OF HOSPIT	AL OR INSTITUTION	if not in ho	spitel, give street address)	d. STREET ADDRES			e. IS RESIDENCE			
		leld State	Hospi			Lyndale A	ve.	YES NO			
	NAME OF DECEASED	First		Middle	Last	4. DATE OF	Month	28, 19 61			
	(Type or print)	Edwa									
3.	Male	White	7. MARRII	THEY ER MARKIED	December 4	-000	67 yrs.   IF UNDER   Months	Deys Hours Min.			
10a	. USUAL OCCUPATION during most of wor	ON (Give kind of working life, even if retire	k   1Db. k	CIND OF BUSINESS OR INDUSTR	Y   11. BIRTHPLACE (Stat	e or foreign countr	y)   12. CIT	TIZEN OF WHAT COUNTRY			
	Rigger (Be	ethlehem St		Company)	Norway		τ	J.S.A.			
13.	FATHER'S NAME				14. MOTHER'S MAIDE						
	Johannas C				Marie 1	Monsal					
15. (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT Address , no, or unknown)   (Ifyasgive war or detas of service)										
	No	-		217-01-1330	Springfi	eld Hospi	tal Records				
			cause par	line for (a), (b), end (c).]	37			ONSET AND DEATH			
	PART I. DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (a) Terminal pulmonary thrombosis and infarction.										
	DUE TO										
	Conditions, if any	years									
	geve rise to immedia (a), stating the un	DITE TO									
	cause last.  (c) General arteriosclerosis - severe.  C.B.S.assoc.with cerebral arteriosclerosis.  C.B.S.assoc.with cerebral arteriosclerosis.										
CERTIFICATION	C.B.S. ass	SIGNIFICANT CONDI	rebra	NIRIBUTING TO DEATH BUT NO	T RELATED TO THE TERM	NINAL DISEASE CO	NDITION GIVEN IN PAR	T 1(a) 19. WAS AUTOPSY PERFORMED? YES NO •			
	20a. EXTERNAL CA PRIMARY Or COI CAUSE OF DEATH.		Ob. DESCR	LIBE HOW INJURY OCCURED. (E	intar natura of injury in P	and I or Pant II of ite	m 1B.)				
MEDICAL	20c. TIME OF INJUI	RY Month, Dey, Ya	Whil		CE OF INJURY (Homa, fa ory, street, offica bldg., a		town) (Cou	unty) (State)			
	21. I certify that I took charge of the remains described above, held an Autopsy . Inspection . Inquiry . and in my opinion										
	death resulted fr	rom: Natural ca	auses	, Accident , Suici	ide, Homicide	Undel	termined manner	The Marie			
		1 4	41	Total	CHIEF MEDICA	L EXAMINER					
10-	SIGNATURE MILES MARSH MARSH M.D. ASSISTANT MEDICAL EXAMINER							DATE SIGNED			
	EXAMINER'S NAME (Type)	James T.	Marsh	n, M.D.		AL EXAMINER	inty)	7/28/61			
228		N, 22b. DATE THERE	OF	22c. NAME OF CEMETERY OR			N (City, town, or country	(Stete)			
	REMOVAL (Specify) Burial	8/1/61	L	St. Paul's C	emetery	Baltin	more, Md.				
23. C	funeral director harles E 3331 Bre	.Schimune	ek Fu	ineral Home		AUG 1 '61	24b. REGISTRAR'S S				
-		Acres August									

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	DIVISION	OF STATISTICA	L RESE					ET, BALTIN	NORE 1, MA	ARYL	AND			
		7809		CERTIFIC	AIL	OF DEAT	111			07	80	1		
1.	PLACE OF DEA a. COUNTY	тн Carroll		MARYLA		2. USUAL RESIDENCE (Where deceased lived, If institution, Rasidence before admission a. STATE Maryland b. COUNTY Carroll								
	b. CITY OR TOWN write RURAL e Finksb	V (if outside corporate limited give nearest town)	ts,	15 yrs		c. CITY OR TOWN (If outside corporata limits, writa RURAL and give nearest lown) Finksburg								
		er Road	f not in h	ospitel, give street eddress)		Gamber Road						ESIDENCE A FARM?		
3.	NAME OF First Middle					Lest 4. DATE Month Day						Yeer		
	(Type or print)	Bertha		Emaline	Ke	eney	OF DEA	TH Jul	Ly 31,		1961			
	sex Pemale	6. COLOR OR RACE	7. MAIN	IED K NEVER MARRIED		Oct. 27, 18	383	9. AGE (In yes	1	YEAR I	IF UNDER Hours	24 HRS. Min.		
			WIDOW					// yrs.	10 61713	IFNI OF	MALATI	OLINITANI		
de	one during most of	ATION (Give kind of work working life, even if retire sewife	d)	KIND OF BUSINESS OR IN	DUSTRY	ii. Birthplace (c Marylar		or foreign count	ry) 12. CI112	U.S		COUNTRY		
1/3	. FATHER'S NAME				14	MOTHER'S MAID	EN NAME							
	Ja	mes E.Morris	3			Emma Ki	ing							
15 (Y.		EVER IN U.S. ARMED FOR (If yes give wer or detes of s	CES? 16	s. social security no.		ORMANT Mary Mais	sel,Ell	icott Ci						
-	18. CAUSE OF DEATH [Entar only one ceuse per line for (e), (b), end (c).]										RVAL BET			
	DADTI DEATH WAS CAUSED BY - 1 7 7 7 1 1 7 6 1 1 1 TOWN ON										SET AND DEATH			
	DUE TO Hypertensive													
	Conditions, it say, which										6 yrs.			
	geve rise to Immediate cause (a), stating the underlying cause last.													
N	PART II. OTH	HER SIGNIFICANT CONDI	TIONS CO	NTRIBUTING TO DEATH B	UT NOT R	ELATED TO THE TER	MINAL DISEA	SE CONDITION	GIVEN IN PART	1(a)   19.	. WAS A			
ATIC	and the same of									YE		RMED?		
CERTIFICATION		WAS UNDERLYING	20b. DI	SCRIBE HOW INJURY OC	CURED. (Er	nter nature of injury	in Pert I or Pe	ert II of item 18.)						
	(IF EITHER, NOTI	FY MEDICAL EXAMINER	n	one										
MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 2Df. (City or lown) (County) (State)  While Not While factory, street, office bldg., etc.)  at work none											(State)		
			atte			-21-41	., 19,	to 7-31-	6 I 19.	the	at (I) (	(we) las		
3	saw the deceased alive on 7-31-61 19, and that death occurred at 30PM from the causes and on the date stated above													
										3-1-6	SIGNED			
A	22c. PHYSICIAN NAME (Type					6 Hanov	er Rd.	Reiste	rstown,	Md.				
23	a. BURIAL, CREMA	ATION, 236. DATE THE	REOF	23c. NAME OF CEME	TERY OR	CREMATORY	23d. L	OCATION (City,	town or county	)	(5)	tete)		
	Burial	Aug.6, 19	961	Finksbur	g Cen	netery	Fi	nksburg	Md.					
24	FUNERAL DIRECT		5	ADDRESS		25e.	REC'D BY REC	61 25b.	REGISTRAR'S S					
	J.F.E	line & Sons,	Keis	terstown, Md.		DATE	AUG 4	01	arthur &	. The	us			

MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND **CERTIFICATE OF DEATH** 07802 7810 director, filed with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased Jimed. If institution: Residence before admission) COUNTY filed b. COUNTY MARYLAND the funeral should be fi b. CITY OR TOWN (If autside carporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outp corporate limits, write RURAL and give nearest town) RURAL and give nearest town) NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? by YES 🔲 NO 🖾 NAME OF First Middle 4. DATE Last Manth Day Year **DECEASED** DEATH (Type or print) 196 campletely fill 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 8-DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Manths Days Haurs WIDOWED Z DIVORCED T USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BUTHPLACE 12. CITIZEN OF WHAT COUNTRY? ring mast af warking life, even if retiged) oug pon 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician with N U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT IS WAS DECEASED EVER event attending pleose INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO been signed by I-transit permit. Canditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last ы PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED! YES | NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING [ certificate OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) factory, street, affice bldg., etc.) Haur a. m. While Nat while at wark at wark p. m. 21. I certify that (I) (this haspital) attended the deceased fram that (I) (we) last M, from the causes and an the date stated above. , and that death accurred at saw the ecceased alive an may be retained by the O FUNERAL DIRECTOR: 22g, SIGNATURE ATTENDING STAFF PHYS. M.D. DIRECTOR [ 226. PHYSICIAN'S 22d. ADDRESS 3 should page 3 sh the State BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State) REMOVAL (Specify ONERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) Thomas 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

death. Page

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) 1. PLACE OF DEATH e. COUNTY b. COUNTY Carroll Maryland Balto City MARYLAND by th c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest town) b. CITY OR TOWN (if outside corporete limits. c. LENGTH OF STAY IN 16 write RURAL end give nearest town) Lmos.5davs Baltimore 5 Sykesville d. STREET ADDRESS IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) ON A FARM? YES NO Springfield State Hospital 2020 McElderry Street NAME OF 4. DATE DECEASED OF Dap John Robert DEATH July Klumpp 61 (Type or print) 19 9. AGE (In yeers | IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED THEYER MARRIED 8. DATE OF BIRTH last birthdey) Months Deys October 29,1888 Male White WIDOWED [ DIVORCED 12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & Stete, or foreign country) done during most of working life, even if retired) U.S.A. Marvland Truck Driver 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Nicholas Klumon Ida Stout 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or detes of service) Springfield Hospital Records No 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Acute renal insufficiency Davs IMMEDIATE CAUSE (a) DUE TO Sensis Davs Conditions, if eny, which geve rise to immediate cause DUE TO (e), steting the underlying C.B.S. assoc. It n cerebral arteriosclerosis. Hypertensive arteriosclerotic Performed? NO TY prior cardiovascular disease. Diabetes Mellitus. 20e. ACCIDENT WAS UNDERLYING 
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) for 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (Stete) 20c. TIME OF INJURY 20d. INJURY OCCURRED Month, Day, Yeer factory, street, office bldg., etc.) While Not While Hour e.m. et work et work DIRECTOR: 21. I certify that (I) (this hospital) attended the deceased from March 20. ..., 19.61, to July 25. ...., 1961, that (I) (we) last 22e. SIGNATURE ATTENDING STAFF DIRECTOR PHYS. PHYS. FUNERAL page with t 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Springfield Hospital, Sykesville, Md. Julian Radcykowycz, M.D. rector, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a, BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Baltimore National Cem. Frederick Rd. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) DATE JUL 2 7 '61 arthur S. Kraus Schimunek Funeral Home Inc. 15M 9/60 2601 E. Madison Street

requires that the

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07804 VISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where-deceased lived. If institution: Residence before admission o. COUNTY COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town RURAL and give nearest Jowh) d. NAME OF HOSPITAL (If not in haspital, give street address d. STREET ADDRESS e. IS RESIDENCE ON A FARM YES NO NAME OF First 4. DATE Yeor Mont DECEASED (Type or print) DEATH 6. COLOR OR RACE AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HR S. SEX 7. MARRIED NEVER MARRIED Months Days Hours DIVORCED [ WIDOWED I 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during mother working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? pod 200 2 WAS DECEASED EVER IN U. S. ARMED FORCES? IN SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Droncho DUE TO A.S. C. W desease Conditions, if ony, which gave rise to immediate DUE TO couse (o), stoting the underlying couse lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING DE CAUSE OF DEATH (IF EITHER, NOTIFY MÉDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20e. PLACE OF INJURY (Home, form, 20f. (City,or town) 20c. TIME OF INJURY Manth. 20d. INJURY OCCURRED Day, Year (Caunty) (Stote) factory, street, office bldg., etc.) ot work ot work that (I) (we) lost 21. I certify that (I) (this haspital) attended the deceased fram. , and that death occurred at MTM, from the couses and an the date stated above. sow the deceased alive on DIRECTOR 226. S GNATURE M.D. PHYS. STAFF PHYS. MED. DIRECTOR PHYSICIAN' 22d. ADDRESS NAME (Type page 3 sh FUNER 23a. BURIAL, CREMATION, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LQGATION (City, town, or county) 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ELINERAL DIRECTOR'S Cithun & Krous VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND **EOR STATE** 7813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before edmission) necessary, ector. Paga e. COUNTY a. STATE b. COUNTY Carrol 1 filas. MARYLAND Maryland Balto, City director. b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1h c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) your Write RURAL and give nearest town)
Syke sville d∜s 2 mos Baltimore 12 IS RESIDENCE unaral dii d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street address) d. STREET ADDRESS Boar ON A FARM? YES NO TO State Springfield State Hospital 6211 Mossway NAME OF 4. DATE Middle Month DECEASED OF DEATH (Type or print) Elsia Tee 1961 Lewis July 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 1886 5. SEX AGE (In years | IF UNDER 1 YEAR) IF UNDER 24 HRS. 2 wit ifter 2, and 3 ga 5 ma 72 had 72 had last birthday) Months Deys Hours Female White WIDOWED [ DIVORCED YIS. Unknown 10a. USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUSTRY | 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired School Teacher ReTIRED U.S.A. Maryland pagas I within 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles E. Lewis Kate Pyle 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no or unkown) (Ifyesgivewerordatesofservice) Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c),] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Arteriosclerotic heart disease " in pencil i Office alon IMMEDIATE CAUSE (e) burial-t DUE TO certificata should Conditions, if any, which (b) rd "pending" i I Examiner's O Se used as a bi geve rise to Immediate cause DUE TO (a), steting the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY C.B.S. associated with senile brain disease, with psychotic reaction. CERTIFICATION YES X NO -Fracture of right hip. P 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of Injury In Part I or Part II of item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. writing to Chief A age s MEDICAL 20c. TIME OF INJURY Month, Dey, Yeer 20d, INJURY OCCURRED | 20e, PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Not While While Hour e.m. el work - at work o execute the certificate, voild be forwarded to the NERAL DIRECTOR: Page 1 prior 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion Suicide Homicide [ Undetermined manner death resulted from: Natural causes Accident CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED should be for SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINÉR'S NAME (Type) James T. Marsh. M.D. Address (Street, city, town, or county) Westminster. Md. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, 220. BURIAL, CREMATION, REMOVAL (Specify) DRUID 0 Buzzal P40 FUNERAL DIRECTOR 24e. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS. A15ME AUG 2 eNN F. Seitz \$204 Y 5M 7/59 arihur S. Krans

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY Baltimore Carroll MARYLAND Maryland b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give negrest town)
Sykesville 3Mos - 2Ldas Baltimore lh. M d. NAME OF HOSPITAL (If not in haspital, give street oddress)
OR INSTITUTION d. STREET ADDRESS IS RESIDENCE 3004 Woodside Ave. YES NO Springfield State Hospital NAME OF Middle 4. DATE Month Yeor DECEASED OF DEATH (Type or print) July 19 67 Charles Albert. Magee 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX NEVER MARRIED lost birthdoy) after Months Hours DIVORCED | WIDOWED | Male 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired)
Machinist Pennsylvania U.S.A. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME David Francis Magee Lewrainer G. Twaddell 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) Springfield State Hospital Records 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Bacteremia DUE TO Conditions, if ony, which Supparative Nephritis gove rise to immediate DUE TO couse (o), stoting the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) SD 20c. TIME OF INJURY Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc. Hour o. m. While Not while ot work ot work p. m. March 21. I certify that (1) (this haspital) attended the deceased fram. saw the deceased alive an , and that death accurred at PM, from the causes and an the date stated above 22o. SIGNATUR SIGNED ATTENDING PHYS. MED. STAFF 22c. PHYSICIAN 3 shauld NAME (Ty page 3 sh the State FUNER 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) REMOVAL (Specify) 01 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATU ADDRESS 25a. REC'D BY REGISTRAR VR A15 (4) Cirthur & Krous 15M 9/59

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## MARYLAND STATE DEPARTMENT OF HEALTH 7815 STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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1. PLACE OF DEATH					2. USUAL o. STAT		here decease	d lived. If institut		e before admi	ission)
Ca	rroll			MARYLAND	0. 31A1		rland	b. COUNTY		City v	
RURAL and give no		ts, write		OF STAY IN 16	11			prote limits, write	RURAL and gi	ve nearest to	wn)
Sykesvi				lmo.24da			Ltimore	е		/ 0	
OR INSTITUTION	AL (If not in hospitol, g				d. STRI	ET ADDRESS				e. IS RI	A FARM?
Springf	ield State	Hosp	ital			Unkr	nown -	Came from	m_jail	· YES [	□ NO 🛣
3. NAME OF DECEASED (Type or print)	Fire Mi]	dred		Middle	[cClana	lost han	4. DATE OF DEATH	Mo Ju		Day	Yeor 19 61
5. SEX	6. COLOR OR RACE	7. MARI	RIED NEVER	R MARRIED	B. DATE OF	BIRTH		9. AGE (In years		YEAR IF UNI	
Female	White	WIDOW	ED C	DIVORCED	July	11, 192	20	lost birthdoy) 40 yrs		Days Hours	s Min.
10a. USUAL OCCUPATIOn during most of work	ON (Give kind of work of ing life, even if retired)	done 10b.	KIND OF BUS	INESS OR INDU	STRY 11. BIR	THPLACE (Store		ountry)	12. CITIZ	EN OF WHAT	COUNTRY!
13. FATHER'S NAME		- 3			14. MOTH	IER'S MAIDEN	NAME				5 6
John McLa	nahan				V	era Fle	eming				
15. WAS DECEASED EVE	R IN U. S. ARMED FOR		SOCIAL SECU	RITY NO. 17. I	NFORMANT	No. L	2175	Add	dress		
(Yes, no, or unknown) NO	pen pen	SI VICE)	-		Spring	field H	Hospita	al Recor	ds		
18. CAUSE OF DEA	TH [Enter only one co	use per li	ne for (a), (b),	ond (c).]						INTERVAL	BETWEEN
PART I. DEA	TH WAS CAUSED BY:	A	cute co	ronary :	insuff	iciency				Hour	
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Conditions, if a	ny, which )	Aı	rterios	cleroti	hear	diseas	se			Year	S
gove rise to in couse (o), stoting								- 111-1-1			
lying couse lost.	(c)							-036			
Schizoph Pulmona	renterated			LO SEATE PU	PASTST.	Piateam *	UNAL BISEAS	E CONDITION GI	VENIN PART		S AUTOPSY FORMED?
(IF EITHER, NOTIFY	S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW IN	NJURY OCCURRI	D. (Enter not	ure of injury in	Port I or Por	t II of item 18.)			
20c. TIME OF INJUR Hour o. m. p. m.	Y Month, Doy, Yes	20d. I While of wor		le fo	ACE OF INJU	JRY (Home, fare office bldg., et	m, 20f. (City	y or town)	(Co	ounty)	(Stote
21. I certify tha	t (1) (this haspital ed alive an Ju	) attend	ded the dec	eased fram.	May 16			July 10,			
220. SIGNATURE	ed alive an out	1, 10	19	-> and that	death accu	rred at4	2.994, -11 am	the causes a	nd an the		22b. DATE
ans	Tris de	10	make	20	M.D. PHYS.	IDING M	AED.	STAFF PHYS.		7/1	SIGNED
NAME (Type)	Agustin (	delCa	mpo, M	.D.		odress pringf	ield H	ospital,	Sykesv	ille,M	
23a. BURIAL, CREMATIO RPMOVAL (Specify)	7-14-	-61	23c. NAME	OF CEMETERY O	R CREMATO	RY	23d. LOCA	TION (City, town,	or county)	Na (St	med.
24. FUNERAL DIRECTOR	S SIGNATURE	16	ADDRES	ille,	nul	250. REC	D BY REGIS		ISTRAR'S SIG	NATURE	

CERTIFICATE OF DEATH Reg. Dist. No. the funeral directar, shauld be filed with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. COUNTY Carroll Co. b. COUNTY MARYLAND Marvland Carroll b. CITY OR TOWN (If autside carparate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Rural Rd Westminster, Md. Rural Westminster. Md. yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? Baltimore Blvd. 22 YES NO NAME OF 4. DATE Middle Manth 15 Effie Susan Dean July Nic Comas DEATH 196I (Type ar print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX B. DATE OF BIRTH Hay birthday) Feb. 29, 1884 Months Days and camplet ban papers. er death. WIDOWED IT DIVORCED | 10a. USUAL OCCUPATION (Give kind of wark done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country)

Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A. Maryland carba 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician Owings Richard Francis E. Shipley 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address Lewis W. McComas Sr. Rd#4 Westminster. Md. 220-05-958ID ding 1B. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (or DUE TO Canditians, if any, which gave rise to immediate DUF TO cause (a), stating the underlying cause last ION'S CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? burial-tr has YES NO Z 20a. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING TI CAUSE OF DEATH ò (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, 20f. (City ar town) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) a. m. While Nat while at wark at wark p. m. 21. I certify that I attended the deceased fram. 1021\_,that I last saw the deceased and that death accurred at DA alive an M. fram the causes and an the date stated above. ADDRESS (Street, city or town, stote) DIRECT ACTUAL Main St. Reisterstown. Md. FUNERAL PHYSICIAN'S Dr. James G. Saffell /Sr. NAME (Type 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, tawn, or county) (State) page REMOVAL (Specify) Deer Park Methodest Cem. Reisterstown. Md. 0 UNERAL DILECTOR'S 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE arihur S. Kraue 15M 9/SB

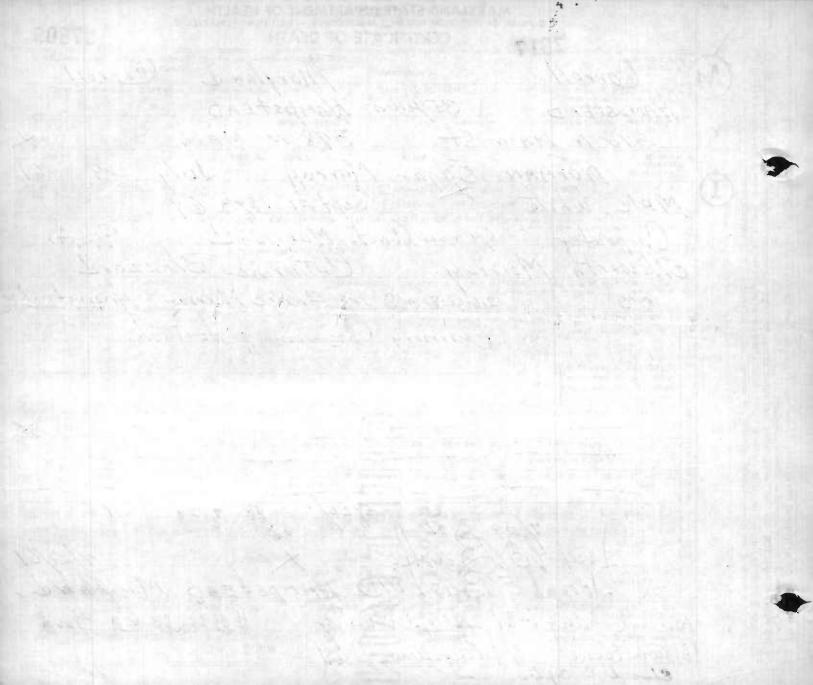
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE I. MARYLAND 07809 CERTIFICATE OF DEATH I directar, filed with 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY MARYLAND arrol b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CHY OR TOWN of outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) **bSTFA** d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET AP DRESS e. IS RESIDENCE YES NOT NAME OF 4. DATE Middle Last Day Year DECEASED DEATH (Type or print) 9. AGE (In yours IF UNDER 1 YEAR IF UNDER 24 HRS SEX 7. MARRIED NEVER MARRIED lost birthooy Months Days Hours after DIVORCED | WIDOWED OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR-INDUSTRY 12. CITIZEN OF WHAT COUNTRY? host of working life, even if retired) 13. FATHER 14. MOTHER'S MANDEN NAME IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT ERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (a), b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' DUE TO Conditions, if ony, which (b) gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Doy. Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) O. m While Not while of work at work p. m. 21. I certify that (1) (this hospital) attended the deceased from ... saw the deceased alive on 1. and that death occurred at M, from the causes and an the dote stated above. OR 220. SIGNATURE M.D. PHYS. DIRECTOR | PHYS. 22c. PHYSICIAN'S 22d. ADDRE NAME (Type tate 23a. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (Stote) poge the St REMOVAL (Specify) 10 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESE 25b. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR AUG VR A1S (4) DATE O-Thur 9 ft 1SM 9/59



VR A15 (4) 15M 9/59

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7219

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1. PLACE OF DI	ATH					2. USUAL RESID	ENCE (WI	here decease				nce befo	re admis	ion)
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b. CITY OR T	OWN (If outside	corporote lim	nits, write	c. LENGTH OF STAT	IN 16	c. CITY OR T	OWN (If	outside corp	orote limit	s, write F	URAL ond	give ne	arest town	1)
and a	al Tanev					X Rt	iral	Tanev	town					
	HOSPITAL (If no		give street	oddress)		d. STREET A							e. IS RES	FARM?
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3. NAME OF DECEASED		Fi	irst	Middle	Lost		4. DATE		Mor	rth.	Do	у	Year	
	(Type or print) Emma.			Savilla	7.00	Ohler	DEATH	J	ulv		23. 19			
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Z PAR	II. OTHER SIGN	VIFICANT CON	NDITIONS C	ONTRIBUTING TO DI	EATH BUT N	OT RELATED TO	THE TERM	INAL DISEA	SE CONDI	TION GI	VEN IN PA	RT 1(o)		AUTOPSY
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OR CONTR	BUTING CAL	ISE OF DEATH (L EXAMINER)	337											
\$ 20c. TIME O	F INJURY Mon	th, Doy, Yo	ear 20d. It	NJURY OCCURRED	20e. PLAC	E OF INJURY (	tome, farn	n, 20f. (Cit	ty or town	}	- 7	(County)		(Stote)
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			t) offend	ed the deceased		1/1	- 4	1. to.						
saw the	deceased oli	ve on	1:0-7	1961 one	d that de	ath occurred	at 1	M, fram	the ca	uses or	nd on th	ne dote		b. DATE
220. 3101	Rullo	194	13/10	NOU		ATTENDING	M	ED.	STAF	F	D	-2	5	SIGNED
22c. PHYSIC	IAN'S	110	Cru-	Ail	М.	22d. ADDRE		IRECTOR L	PHYS	-Cil.	11000	5.1	1-61	
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22- 0110141 55	J VIV	DATE THERE	110	11/139	V /*[1]	CREWATORY		5/1	121	LIKE	7, 1	-17-		
23a. BURIAL, CE REMOVAL	Specify)	-		23c. NAME OF CEA	_	T-100		23d. LOC				_	(Sto	le)
Buria	I JU	Lly 27	1961	Luthera	in Cem	etery	05	-			laryl		105	
24. FUNERAY DI	KILCTOR'S SIGNI	Pel	Cul	ADDRESS				D BY REGIS			STRAR'S S			
C.O.F	uss & Sc	n	Tane	ytown, Mar	yland		DATE	De De S						

resident fill (and property and the contract of the contract o the fourth share the CONGRESSION THORN SUCCESSION SINGLESSION STATES THE COLUMN THE WALLEST CHEST

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7810

07811

1. PLACE OF DEATH o. COUNTY Car	roll		MARYL	- 11	o. STATE		land	l lived. If institu b. COUNT				ion
b. CITY OR TOWN (If or RURAL and give neare Sykesville	utside corporate limi est town)	its, write	c. LENGTH OF STAY IN	N 16	c. CITY OR TOW Balt:		re 24	rote limits, write	RURAL ond	give nea	rest fown	-1
d. NAME OF HOSPITAL		give street			d. STREET ADDR	RESS					e. IS RES	FARM?
Springfiel	d State H	lospi	tal		323	S.	Bouldi	n Stree	t			NO [3
3. NAME OF DECEASED (Type or print)	John	rst	Middle Joseph		Ovelgone	e	4. DATE OF DEATH	Jul	onth	10,		Yeor 1961
5. SEX 6	COLOR OR RACE White	7. MARR	NEVER MARRIED DIVORCED	_	Date of Birth December	2,		9. AGE (In year lost birthdoy)	Months	Doys	Hours Hours	Min.
10a. USUAL OCCUPATION during most of working Trucking -	(Give kind of work life, even if retired Penna Rai	KIND OF BUSINESS OR	INDUSTR	The state of the s	(Stote		ountry)	12. CIT		WHATC	OUNTRY	
13. FATHER'S NAME	TE TO SERVICE	1707		1	14. MOTHER'S MA	IDEN N	NAME					
Henry Ovels	gone				Mary :	Sib	er					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (fet, no. or unknown) (If yes, give wor or dates of service)												
(Yes, no, or unknown) (If y	es, give war ar adies or :	ervice			Springf	iel	d Hosp	ital Re	cords			A.L
PART I. DEATH	WAS CAUSED BY: MEDIATE CAUSE (c	Br	ne for (o), (b), ond (c).]	onia						ONS	RVAL BE ET AND ays	
Iying couse lost.  C.B. PART II. OTHER C.B. S. 25500  200. ACCIDENT WAS I OR CONTRIBUTING DOWN (IF EITHER, NOTIFY ME	SIGNIFICANT CON		CONTRIBUTING TO DEADS OF UTICET C					Chorea)	even in par ton's	RT 1(o)-1	9. WAS PERFO YES	AUTOPSY PRMED? NO 3
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Ye	While	NJURY OCCURRED  Not while k of work		OF INJURY (Hom y, street, office bld			or town)	(	(County)		(Stote)
saw the deceased 220. SIGNATURE		ly 10	led the deceased f		ATTENDING PHYS.	2*2					stated	
M2c. PHYS/CIAN'S NAME (Type)	lgustin de	elCam	po, M.D.		22d. ADDRESS Spring	fie	ld Hos	pital,S	ykesvi	lle	Md.	
230. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREG	OF	23c. NAME OF CEMEN				23d. LOCAT	TION (City, town	yland		(Stot	te)
24. FUNERAL DIRECTOR'S S Ullrich Fune		. Dun	ADDRESS	1.920	250		D BY REGIST	RAR 2Sb. REC	GISTRAR'S SI			

HARD TO STANGED TO THE PERSON Man I was been been been been and the state of t

detached far use as the burial-transit permit

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	•	1	1

JNERAL DIRECTOR: After this certificate has been signed by ge 3 shauld be detached far use os the State Board of Health prior to burial,

1	
directar,	3. 1 1.3

CERTIFICATION

		10 5	Dd.	Ine
VR 15	A	9/5	9	

TICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

07812

1.	o. COUNTY Ca	rroll		MARYLAND	2. USUAL RESIDENCE OF STATE		ere decessed	l lived. If institution b. COUNTY	-		· Cit	1
	b. CITY OR TOWN (I RURAL and give ne Sykesv		ls, wrile	c. LENGTH OF STAY IN 16			iside corpoi	rote limits, write R	URAL ond	give nec	presi lowr	4
	OR INSTITUTION	AL (If not in hospital, g			d. STREET ADDRESS  e. IS I							FARM?
3.	NAME OF DECEASED (Type ar print)	Raymon		Archie	Phebus		4. DATE OF DEATH	Month July		Doy 13,		Year 19 61
S.	Male	6. COLOR OR RACE White	June 3, 1	Months Months	R 1 YEAR Days	Hours	Min.					
100	during most of work Banking	ON (Give kind af work of king life, even if retired	dane 10b.	KIND OF BUSINESS OR INDU		(Stote o		ountry)	12.CI	U.S	·A.	OUNTRY
13.	Eugene Ph	ebus			Florence Miller							
		R IN U. S. ARMED FOR (If yes, give war or dates of s		216-03-8008	NFORMANT Spring	fie:	ld Hos	Add Spital Re		S		115
		ATH [Enter only one co ATH WAS CAUSED BY: IMMEDIATE CAUSE (o DUE TO	)R	ne for (o), (b), and (c).] heumatic heart	disease					ONS	ERVAL BE SET AND Cars	DEATH
	Conditions, if a gave rise to i cause (o), stoting	mmediate (					13 C					

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Presentle psychosis. Pick's Disease of the brain.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 ar Part II of ilem 1B.)

200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

MEDICAL 20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.) 20f. (City or town) (Stote) (County) a. m Not while at work p. m. 1966 to July 13. ... 1961, that (1) (we) last

21. I certify that (I) (this haspital) attended the deceased from March saw the deceased alive an July 13, 19 61, and that death acc and that death accurred at 2:45P. From the causes and an the date stated above. 22a. SIGNATURE MED.

ATTENDING PHYS. 22d. ADDRESS

23b. DATE THEREOF

Springfield Hospital, Sykesville, Maryland

YES NO

23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) Druid Ridge Cemetery Baltimore, Maryland

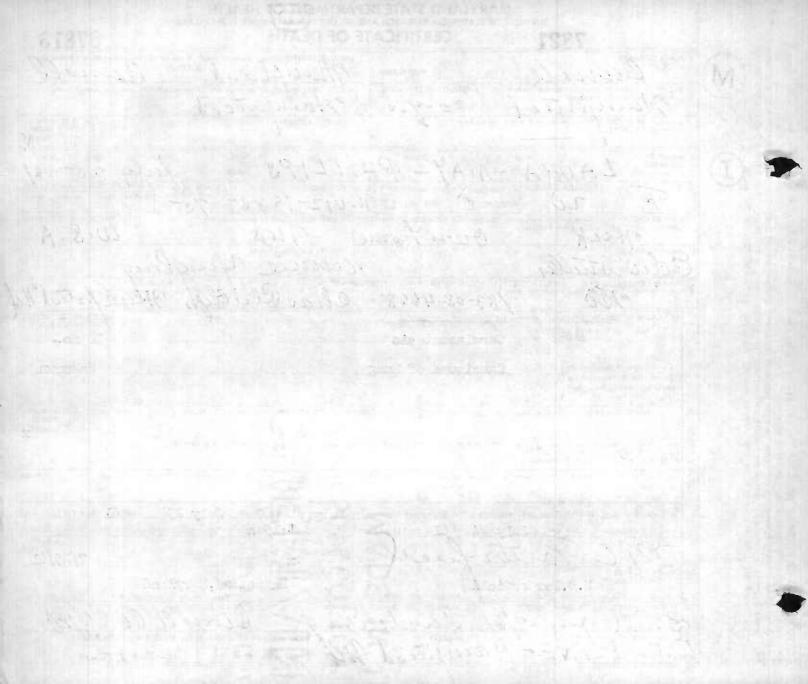
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial F4600 MISETTY Heights Averson REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE

new in the next times, my PERSONAL PROPERTY OF THE PROPE 

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7827 director, iled with Poge 1 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admissionfiled o. COUNTY b. COUNTY MARYLAND the funeral a b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) RUBAL and give nearest town) d. NAME OF HOSPITAN d. STREET ADDRESS e. IS RESIDENCE (If nat in haspital, give street address) OR INSTITUTION ON A FARM 67 YES NO . = NAME OF Middle DATE Year DECEASED DEATH (Type ar print) death 9. AGE (In years last birthday) IF UNDER I YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH Months Days after WIDOWED I DIVORCED | 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address 17 INFORMANT NTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c). ONSET AND DEATH a PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) 18 ma Carcinomatosis DUE TO p Conditions, if any, which Carcinoma of Lung Unknow gave rise to immediate DUE TO cause (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO R 20a. ACCIDENT WAS UNDERLYING A CONTRIBUTING A CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, Day, Year 20f. (City or tawn) (Caunty) (State) foctory, street, office bldg., etc.) Haur o. m. Nat while D at wark at work p. m far prior pached July 24-19-61, and that death accurred a 15Mafrom the causes and an the date stated above saw the deceased alive an DIRECTOR 22b. DATE SIGNED M.D. PHYS. DIRECTOR T 6 22c. PHYSICIAN'S 22d. ADDRESS 3 shauld NAME (Type) Hampstead, Maryland M.C. Porterfiel TO FUNERAL 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) FUNERAL DIRECTOR'S SIGNATUR ADDRESS 25a. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE DATE JUL 2 8 '61 VR A15 (4) arthur S. Kraus 1SM 9/59

after death.

MARYLAND STATE DEPARTMENT OF HEALTH



RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7822 funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) e. COUNTY b. COUNTY by the and 2 s death. MARYLAND Maryland Carroll Garroll b. CITY OR TOWN (if outside corporale limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest lown) write RURAL and give nearest town) Sykesville Westminster
d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 50 John St. State Hospital 3. NAME OF 4. DATE DECEASED OF DEATH (Typa or print) Belle PHILLIPS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR last birthday) Months WIDOWED TO DIVORCED female 10a. USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if ratired) Housewife Carroll, Maryland attending ph 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME plea Thomas Edmondson Parrish 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yas, no, or unkown) | (Ifyes giva war or dates of service) Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c),) PART I. DEATH WAS CAUSED BY: Active pulmohary TB - advanced. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immadiata causa DUE TO (e), steting the underlying causa lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 1 19. WAS AUTOPSY CBS assoc. with carebral arteriosclerosis, with psychotic reaction.

2Da. ACCIDENT WAS UNDERLYING | | 20b. DESCRIBE HOW INJURY OCCURED. (Entar natura of injury in Part I or Part II of itam 18.)

OR CONTRIBUTING | CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED | 2De. PLACE OF INJURY (Homa, farm, 2Dc. TIME OF INJURY Month, Day, Year 2Df. (City or town) (County) factory, streat, office bldg., atc.) Whila Not While Hour e.m. at work 21. I certify that (I) (this hospital) attended the deceased from 2/28/60......, 19....., to 7/22/61....., 19....., that (I) (we) last saw the deceased alive on ..... 7.122 22a. SIGNATURE DIRECTOR PHYS. PHYS. death. Page 4 page 22d. ADDRESS 22c. PHYSICIAN'S NAME (Typa) Julian Radzykewycz. Springfield Hospital, Sykesville, director, filed 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23e. BURIAL, CREMATION, 23b. MOVAL (Spacify) 24 FUNERAL DIRECTOR'S SIGNATURE 25. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 9/60 arthur & Kraus

a. IS RESIDENCE ON A FARM? YES NO

1967

IF UNDER 24 HRS.

INTERVAL BETWEEN ONSET AND DEATH

PERFORMED?

NO T

(State)

22b. DATE

SIGNED

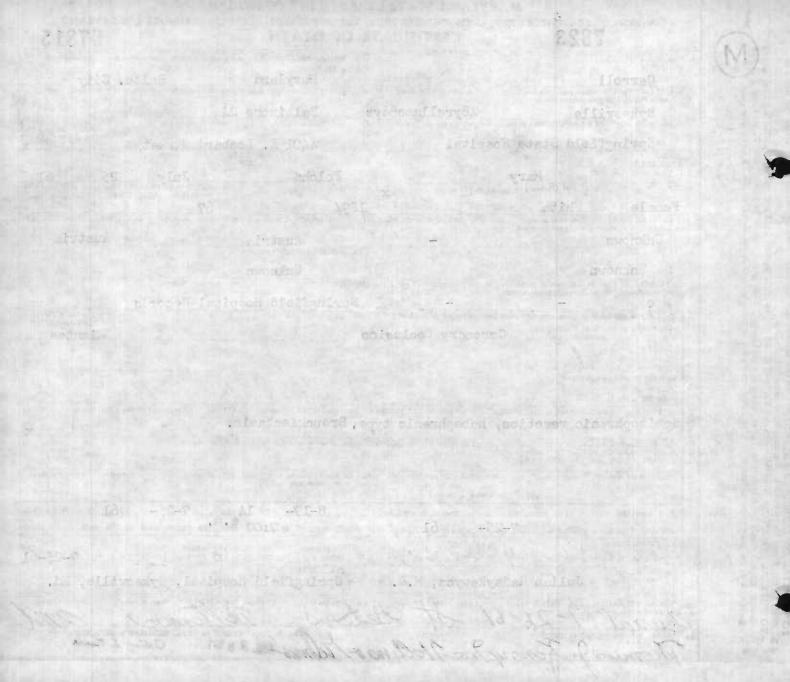
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2222 Profes leading to the sent of the non-River of the Affiliation of the sent of ME. THE RESERVE OF STREET Absorption with thodor in avioni 12 in The second secon ic same with the toll transmitted to the state of the same state of State of the Property of Contact Conta Joseph John Man Market Me and the Comment of the Co

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Carroll Balto, City by the and 2 death. MARYLAND Maryland b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town write RURAL end give nearest town) 46yrsllmos6dvs filled in Pages 1 urs after Sykesville Baltimore 24 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO Lombard Street 3. NAME OF DATE Middle Day DECEASED OF (Type or print) DEATH 196] Marv Poloha July within 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. and last birthdey) Months Deys White Female WIDOWED DIVORCED 1894 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foraign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working lifa, even if retired) Unknown Austria Austria 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ding Unknown Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give war or detes of service) Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH DEATH WAS CAUSED BY: Coronary Occlusion Minutes IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immediate cause DUE TO (a), steting the underlying couse last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8): 19. WAS AUTOPSY PERFORMED? 38 Schizophrenic reaction, hebephrenic type. Bronchiectasis. NO prior use 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Pert II of item 18.) 2Da. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH DIRECTOR: After the 2Dd. INJURY OCCURRED | 2De, PLACE OF INJURY (Home, ferm, 20c. TIME OF INJURY 20f. (City or town) (County) (State) Month, Day, Year factory, straet, office bldg., etc.) While Not While Hour a.m. et work at work 21. I certify that (I) (this hospital) attended the deceased from 8-19-, 19.14 to 7-25-, 1961, that (I) (we) last SIGNATURE ATTENDING SIGNED DIRECTOR X PHYS. PHYS. M.D. FUNERAL page with th 22d. ADDRESS PHYSICIAN'S NAME (Type) Julian Radzykewycz. M.D. Springfield Hospital, Sykesville, Md. ector, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stata) 23a. BURIAL, CREMATION, 23b. REMOVAL (Specify) 0 250, REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) arthur S. Thous 15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH



Page

death.

e. IS RESIDENCE ON A FARM?

INTERVAL BETWEEN ONSET AND DEATH

WAS AUTOPSY

PERFORMED? YES NO BE

(State)

22b, DATE SIGNED

(Stote)

Day

Dovs

YES NO

Year

HILESPIN STEELS STEELS THE WEST OF STREET, SAN SON STREET, THE WAR WITH

1		Division of	STATISTICA		CH AND RECOR					ORE 1.	MARY	/LANE	
FOR STATE				DICAL		R'S C	ERTIFICAT		DEATH	- 1,	07	217	,
HEALTH DEPT.		PLACE OF DEATH				2.	USUAL RESIDEN	CE (Where d	decaesed lived, If	Institution	Residance	e bafore	admission)
Page iles. ealth,			roll		MARYLAI		Marylar		b. COUN	Balto			
The ctor.		<ul> <li>b. CITY OR TOWN (i write RURAL and</li> </ul>	f outside corporata li giva naarast town)	mils,	c. LENGTH OF STAY IN	1 16	c. CITY OR TOWN (	If outside con	porale limits, write	RURAL	nd give n	eerest tov	vn) (1
(Ne 1 2 2		Sykesvil			3 days		Baltimo	ore		-	SV	0.1	-/
3000					pitel, give street address)		d. STREET ADDRESS					ON	A FARM?
事言語	3.	Springii NAME OF	eld State		Middle		1818 E.	Balt:	imore St	reet	Day	YES Yes	
the She S		DECEASED (Type or print)		sie	Middle		Rawlins	OF DEATH			17		
## ## ## ## ## ## ## ## ## ## ## ## ##	5.	SEX			D NEVER MARRIED	7   8. DA	ATE OF BIRTH		9. AGE (In years		31 I YEAR	IF UNDER	61 R 24 HRS.
and and 2 will ours		Female	White	WIDOWE		1		8- 5-	last birthday)	Months	Days	Hours	Min.
after 2, 8	108	. USUAL OCCUPATI	ON (Give kind of wo	ork 10b. K	IND OF BUSINESS OR INC	USTRY 1	1. BIRTHPLACE (State	or foreign co	miles a	12. CI	TIZEN OF	WHAT (	COUNTRY?
Pag s 1 a		TIMA	neoww	190)	Unk		Unka	nown			U.S	.A.	
Page Withi	13.	FATHERES NAME				14.	MOTHER'S MAIDEN						
Fire Park			nown				Unknow	m			- 14		
=		WAS DECEASED EVI			SOCIAL SECURITY NO.				Address				
with the sample any	-	NO 18 CAUSE OF D	EATH lenter only of	no causa nor li	ina for (a), (b), and (c).]	SI	ringfield	Hospit	tal Recor	rds	LINITI	ERVAL BET	TWEEN
in J in J in J in J in J					ening of the	hre	in				ON:	Days	DEATH
ancije Prancije -i-tran		337	DUE TO		anting of one	Dra.	An d. A.		200			-ay b	
uld lin pe		Conditions, if any			tid artery t	hrom	bosis					Days	
sho s s o s o s o s o		geve rise to immedia	eta causa		onary edema				W			Hour	
cate ondire d as		cause last.	and the state of		ardial failu	re						Days	714-
Exan Exan use tion	NO O	PART II. OTHER	SIGNIFICANT CON	DITIONS CON	TRIBUTING TO DEATH BU	JT NOT RE	LATED TO THE TERMIN	NAL DISEASE	CONDITION GIV	EN IN PAR	T 1(a) 15	PERFO	AUTOPSY DRMED?
ord	ICAT						President.	-4.7			Y		NO -
Aedica hould tree	CERTIFICATION	20a. EXTERNAL CA PRIMARY ☐ or CO		206. DESCRI	BE HOW INJURY OCCUR	ED. (Enter	nature of Injury In Par	t I or Pert II o	of itam 1B.)				
writing the Chief A sge 3 s	1	20c. TIME OF INJU	RY Month, Day, 1	Year   20d	NJURY OCCURRED   20e	PLACEC	OF INJURY (Home, farm	20f (CII	ty or town)	ICo.	unly)		(State)
Armin Walin	MEDICAL	Hour a.m.	19	While			street, office bldg., atc.		, 0. 10 111,	100	J.,		(Jiara)
Cafe, the the prior	1				ains described above	e, held a	n Autopsy X	Inspection	Inquir	y <b>y</b> ,	and	in my o	pinion
発音を記号		death resulted f	rom: Natural	causes X	Accident ,	Suicide	, Homicide	M, Ur	ndetermined m	anner	7		
C S D M S			0	2	1		CHIEF MEDICAL	EXAMINER [					
		ACTUAL SIGNATURE	tances	2. /	Koneh	/	M.D. ASSISTANT MED	ICAL EXAMIN	NER 🗌		D	ATE SIG	NED
		EXAMINER'S	James T.	Moreh	M D		DEPUTY MEDICAL		Palent			-31-6	51
	228	NAME (Type)			22c. NAME OF CEMETER	RX OR CRA			County) West			Md (Sial	
0 4		REMOVAL (Specify)	8-3-	101	Allas 1	AN .	/	El	in PA	v/	14	ens	
A A	23.	FUNETAL DIRECTOR	2 11	ha	ADDRESS	11	/ 24a. REC	D BY REGIST	R 24b. REG	ISTRAK'S	SIGNATU		
VS. A15ME 5M 7/59	1	retur !	H. Haly	all !	Hypesoul	le:	Mel. DATE AL	JG 3	61 a	rthug &	8 Kar	4.4	
	4							- Transfer					

HES TO THE REPORT OF THE PARTY CARRIED TO LABOR TO BERNE THE PERSON NAMED IN all all the state of the state . Breating a piet (C. 22) · All . TEARS LECK!

1	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
	CERTIFICATE OF DEATH  Reg. Dist. No. 07818
director, filed of the A	1. PLACE OF DEATH a. COUNTY Carroll  AMARYLAND  2. USUAL RESIDENCE (Where deceosed lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll
erol be	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  RURAL and give nearest town)  Westminister  c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Frizzelburg
s after y the 2 shou	d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION Carroll Co. Home for Aged  d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES \( \) NOT
filled in b	3. NAME OF DECEASED (Type or print) James Roy Sherfey Lost 4. DATE OF DEATH July 23 19 61
Po Po	5. SEX  6. COLOR OR RACE  7. MARRIED NEVER MARRIED 8. DATE OF BIRTH  8. DATE OF BIRTH  9. AGE (In yeors lost birthdoy)  White WIDOWED DIVORCED Sept. 12, 1890  9. AGE (In yeors lost birthdoy)  Months Doys Hours Min.
e be executed v ian and complet carbon papers.	10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  None  10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country)  Maryland  12. CITIZEN OF WHAT COUNTRY?  U.S.A.
	13. FATHER'S NAME  Samuel D. Sherfey  Amanda Kump
certifical ng physic remave 72 haurs	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. or unknown) (If yes, give wor or dates of service)  None
SICIAN: The law requires that the death cer ottending physician. certificate has been signed by the attending is as the burial-transit permit. Then please retion, or remaval, and in any event within 72	18. CAUSE OF DEATH [Enter only one couse per line, for (o), (b), and (c).]  PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (o)  DUE TO  Conditions, if dry, which gove rise to immediate couse (o), stating the under-lying couse lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED?  YES NO  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote)
G PHYS  pital ar c  r this ce  for use c  crematic	Hour o. m. p. m.  19 While Not write of work o
ATTENDIN by the host ITOR: Afte detoched to to burial,	21. I certify that I attended the deceased fram 1955, 19, to 7 - 2 2, 196, that I last saw the deceased alive an 2 - 2 196, that I last saw the deceased alive an 3 - 2 2, 196, that I last saw the deceased alive and alive an 3 - 2 2, 196, that I last saw the deceased alive and alive an 3 - 2 2, 196, that I last saw the deceased alive and alive a
AL OR A retained b	PHYSICIAN'S NAME (Type)  ACTUAL SIGNATURE 7, C. S. LOZIO M.D. TYZST 911-11-23-2  PHYSICIAN'S NAME (Type)
HOY be roy be roy age 3 s e regist	220. BURIAL, CREMATION, 22b. DATE THEREOF Creagerstown Cemetery Creagerstown, Md. (Stote)
Q E Q & £ VS A15 (4) 1SM 9/S8	23 FUNERAL DIRECTOR'S SCHATTLES ADDRESS  ADDRESS ADDRESS DATE 10 246. REGISTRAR'S SIGNATURE  DATE 11 25'61  Civilian & Thomas

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DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7827 il directar, filed with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY a. STATE b. COUNTY MARYLAND after death. the funeral shauld be fi b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 CITY OR TOWN of outside corporate limits, write RURAL and give nearest town) RURAL opd give neorest town d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS OR INSTITUTION ON A FARM? 24 YES NO and .5 NAME OF 4. DATE First Middle Month Day Year DECEASED (Type or print) DEATH death IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED # B. DATE OF BIRTH 9. AGE (In years) campletely lost birthdoy) after Months Doys Hours WIDOWED [ DIVORCED | papers. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY dring most of working life, even if retired) haurs 11. BIRTHPLACE (Stote of foreign country 12. CITIZEN OF WHAT COUNTRY? and ban 14. MOTHER'S MAIDEN NAME within physician the death certificate 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMAN (If yes, give wor or dates of service) attending 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DE ā PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) oud DUE TO by Conditions, if ony, which been signed gove rise to immediate per DUE TO couse (o), stoting the underlying couse lost the burial-transit 20 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY crematian. PERFORMED? After this certificate has YES 🗍 NO I ar attending 20b. DESCRIBE HOW INJURY OCCURRED. Tenter nature of injury in Port I of Port II of item 18 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER os MEDICAL 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Doy, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) use Hour o. m. While Not while 0 ot work ot work p. m far prior 21. I certify that (I) (this haspital) attended the deceased from that (1) (we) last detached sow the deceosed olive on ~19 ond that dooth occurred a M, from We codes and an the date stated obave. DIRECTOR: 22o. SIGNATURE 22b. DATE M.D. PHYS. DIRECTOR | PHYS. 22c. PHYSICIAN 22d. ADDRESS NAME (Type O FUNERAL page 3 the Stat 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) MOVAL (Specify the 24 FUNERAL DIRECTOR'S SIGNATURE 25b. REGISTRAR'S SIGNATURE **ADDRESS** D BY REGISTRAR arthur S. Kraus VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

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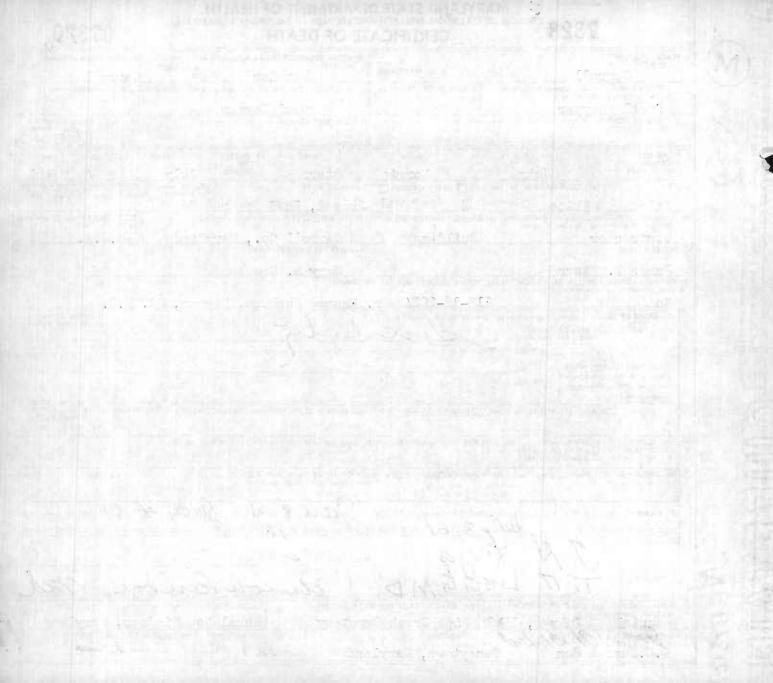
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

07820

1. PLACE OF DEATH o. COUNTY Carr	017		MAR	rLAND 2.	usual RESIDENCE a. STATE	(Where decease	sed lived. If institut b. COUNTY			sion)
b. CITY OR TOWN (If RURAL and give ne	outside corporate limits	, write c	LENGTH OF STAY	IN 1b	c. CITY OR TOWN	200 00 7 7 00		002202	to fail a	n}
	AL (If nat in hospital, given	ve street ad	dress)		d. STREET ADDRES		<u> </u>			SIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	First John		Middle Nor:		Starr	4. DATE OF DEAT		nth	Day 4	Year 1961
5. SEX	6. COLOR OR RACE	7. MARRIEI			vate of Birth	75	9. AGE (In years last birthday) 86 yrs	Months Days		ER 24 HRS. Min.
	ing life, even if retired)				11. BIRTHPLACE (S			12.CITIZEN		COUNTRY
Contracto 13. FATHER'S NAME	r		Building	1	4. MOTHER'S MAIDE		aryland	l U.S.	A	
James T.		ree la con		1.7 1150	Mary R.	Crouse				
15. WAS DECEASED EVER (Yes, no. or unknown)	IN U. S. ARMED FORC If yes, give war or dates of ser	vice)	5-18-2924		RMANT Neurow Nus	sbaum.		dress		
	TH [Enter only one cau TH WAS CAUSED BY: IMMEDIATE CAUSE (a).	se per line	for (o), (b), and (c)		lili	_		IN.	NTERVAL BI	ETWEEN DEATH
794;	DUE TO	7			1					
Conditions, if or gove rise to in couse (a), stating t lying couse lost.	nmediate ( DUE TO									
PART II. OTH  PART II. OTH  200. ACCIDENT WA  OR CONTRIBUTING  (If EITHER, NOTIFY	ER SIGNIFICANT COND	ITIONS <u>CO</u>	NTRIBUTING TO DE	ATH BUT NO	OT RELATED TO THE T	ERMINAL DISEA	ASE CONDITION G	IVEN IN PART 1(0)	PERFO	AUTOPSY DRMED?
	S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESCR	IBE HOW INJURY (	OCCURRED. (	Enter noture af injury	y in Port I or P	ort II af item 1B.)			
20c. TIME OF INJURY Haur o. m. p. m.	Month, Day, Year	While of work [	URY OCCURRED Not while of work	20e. PLACE foctor	OF INJURY (Home, y, street, office bldg.	farm, 20f. (C	ity or town)	(Cauni	ly)	(Stote
21. I certify that saw the decease	t (I) (this haspital) ed alive an	attende	111		Jan 8. The accurred at	196/ta	The causes a		that (1) ite stated	
220. SIGNATURE	7 19	Le	30	M,D	ATTENDING PHYS.	MED. DIRECTOR [	STAFF PHYS.		22	2b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)	T. H.	11:0	15M	D	22d. ADDRESS	ion	Bui	dge	7	red
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		1961	23c. NAME OF CEA				CATION (City, town,		(Sto aryla	,
24. FUNERAL DIRECTOR	SIGNATURE Bile	1	ADDRESS			REC'D BY REG	ISTRAR 25b. REC	istrar's SIGNA		

ours after death. Page 4 g physicion and completely filled in by the funeral director, remaye carban papers. Pages 1 and 2 shauld be filled with may be teknined by the hospital or attending physician.

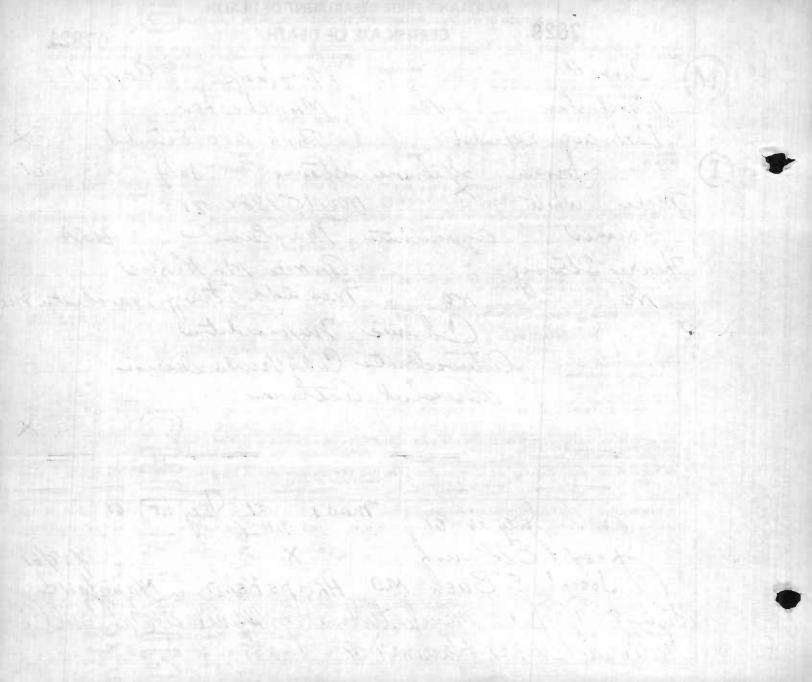
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled page 3 shauld be detached far use os the burial-transit permit. Then please remave carban papers. Pages 1 the State Board at Health priar to burial, cremation, or removal, and in any event, within 72 hours after death AL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 TO HO VR A15 (4) 15M 9/59



VR A15 (4) 15M 9/59

7829 CERTIFICATE OF DEATH

	1823		CERTIFIC	CATE OF DEATH	1		0782	1
D. COUNT			MARYLA	ND 2. USUAL RESIDENCE (V		If institution: Reside	re before admiss	ion)
RURAL and give	(If outside corporate neglest town)	limits, write c.	LIFE	c. CITY OR TOWN (I	outside corporate lin	mits, write RURAL and	give nearest tawn	*)
	PITAL (If not in hospit	Eltene	dress)	d. STREET ADDRESS	k ave.	Extend	e. IS RES ON A YES	FARM?
NAME OF DECEASED (Type or print)	Sam	First	Lilmo	e Strevis	4. DATE OF DEATH	July Month	- 0	Yeor 19 <i>61</i>
male	While	CE 7. MARRIED	NEVER MARRIED  DIVORCED [		1889 9. AG	E (In years birthdoy) yrs. IF UNDE Months	Days Hours	Min.
oa. USUAL OCCUPA during most of w	TION (Give kind of working life, eyen if re	ark dane 10b. KII (ired)	ND OF BUSINESS OR I	NOUSTRY 11. BIRTHPLACE (Sto	le or fareign country)	12.C11	PUSA	OUNTRY
3. FATHER'S NAME	Strew	ig		14. MOTHER'S MAIDEN	M.	Kehler		
5. WAS DECEASED E	VER IN U. S. ARMED (If yes, give war or date	FORCES? 16. SO	CIAL SECURITY NO.	17. INFORMANT Mes as	la Str	May, Ma	vehed	tw /
	DEATH [Enter only or DEATH WAS CAUSED IMMEDIATE CAUSED	BY:	forto (b), oft (c).]	ie nur	conditi	3.	ONSET AND	TWEEN
Conditions, if gove rise to couse (o), stotic lying cause los	ony, which immediate ong the under-	(b) G1	Ernelie	tie Cardio C	Pasculu .	Deserie		
PART II. C	OTHER SIGNIFICANT	CONDITIONS COL	NTRIBUTING TO DEATH	BUT NOT RELATED TO THE TER	MINAL DISEASE CON	IDITION GIVEN IN PA	RT 1(a) 19. WAS PERFO YES	AUTOPSY PRMED?
	WAS UNDERLYING L NG D CAUSE OF DE FY MEDICAL EXAMIN	ATH	BE HOW INJURY OCC	URRED. (Enter noture of injury i	n Part I or Port II of	item 18.)		_
20c. TIME OF INJ Hour a. n p. n	n	While	URY OCCURRED 20 Not while of work	e. PLACE OF INJURY (Hame, fa factory, street, office bldg., e	rm, 20f. (City or to	wn)	(County)	(Stote
	hat (I) (this hosp	(1) attended	the deceosed fr	am Marel 1 1912	30M, from the		that (I) (	
22a. SIGNATURE	expel	EB	rush.	M.D. ATTENDING PHYS.		AFF YS.		SIONED
22c. PHYSICIAN'	Joseph	E.B	ush M	D HAMP	STEAD	Ma	nylan	2
REMOYAL (Spec	1/31/	G/	Manches	to senty	Mane	Chy, tawnfor country)	arrot	Ma
STICO (1)	will Su	cher	Haumi	S TO DATE	C'D BY REGISTRAR	25b. REGISTRAR'S S		



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LAND STATE DEPARTMENT OF HEALTH

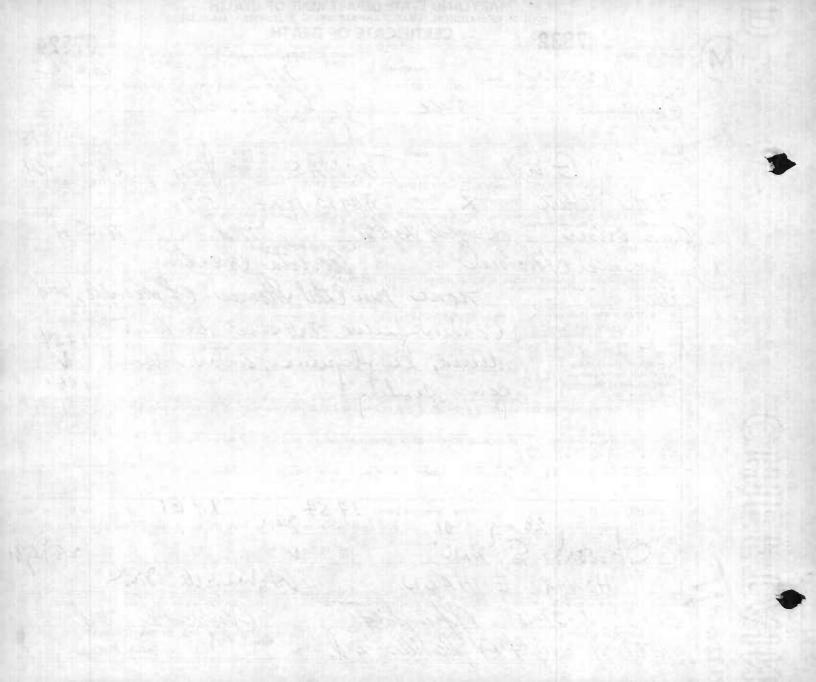
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND OF DEATH funeral 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) 1. PLACE OF DEATH b. COUNTY Carroll . COUNTY Carroll Maryland MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give neerest town) Finksburg Vrs. Finksburg .= filled d. NAME OF HOSPITAL OR INSTITUTION (if not In hospitel, give street eddress) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? Old Westminster Road Old Westminster Road YES NO T 3. NAME OF Middle 4. DATE Month Day Yaer DECEASED John Martin DEATH July 16. (Type or print) Taylor 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 8. DATE OF BIRTH last birthdey) Months | Deys Male WIDOWED TO DIVORCED 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired! England Turnkev at Jail England 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please attending Frederick Taylor Orpah Martin IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or detes of service Mrs.Mildred DeMoss, Finksburg, Md. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one ceuse per ONSET AND DEATH I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if env. which gave rise to immediate cause DUE TO (a), steting the underlying ceuse lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO? RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPS PERFORMED 200. ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCUPED, (Enter nature of injury in Pert I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED LEOS. PLACE OF INJURY (Home, farm, 20f. (City or town (County) (State) factory, street, office bldg., etc. Not While Hour a.m. al work at work 21. I certify that (I) (this hospital) attended the deceased from... saw the degeased alive on. 22b. DATE 22a. SIGNATURE ATTENDING STAFF MED DIRECTOR PHYS. PHYS. FUNERAL 22d. ADDRESS 22c. PHYSICIAN ector, WAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or gounty) 23a. BURIAL, OREMATION, | 23b. DATE THEREOF REMOVAL (Specify) の意義 St. Thomas Cemetery Owings Mills, Md. 25e. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) arthur S. Kraus J.F. Eline & Sons, Reisterstown, Md. 15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH filed with director PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence be o. COUNTY b. COUNTY MARYLAND funeral ald be fi b. CITY OPTOWN (If outside corporate limits, write RURA) and give nearest to you C. LENGTHOOF STAY IN 16 c. CITY OR TOWN (If Jourside posporate Jimits, write RURAL and give nearest town) pluods Mucull d. NAME OF HOSPITAL (If not in haspital, give street address)
OR INSTITUTION e. IS RESIDENCE d. STREET ADDRESS ON A FARM? by YES NO NAME OF 4. DATE Middle Last Month Year Day DECEASED DEATH (Type or print) AGE (In years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 H S. SEX 6. COLOR OR RACE . MARRIED NEVER MARRIED B. DATE OF BIRTH Manths Doys Hours DIVORCED | WIDOWED M 10a. USUAL OCCUPATION (Give kind af work done 10b KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stote or foreign country) ouring most of warking life, even if retired) 12. CITIZEN OF WHAT COUNTRY? 14. MOTHER'S MAIDEN NAME 13. FATHERAS NAME physician COL .⊆ with 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT yes, give war or dates of service) yoursvelle, attending INTERVAL BETWEEN 1B. CAUSE OF DEATH [Enter anly one cause per line for (o), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO by Conditions, if any, which gave rise to immediate **DUE TO** couse (o), stoting the underlying couse last. ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITI PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING A CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) 20c. TIME OF INJURY 20d. INJURY OCCURRED Month. Day, Year (County) (Stote) foctory, street, office bldg., etc.) Hour a.m. Nat while While at wark ot wark p. m. 21. I certify that (1) (this hospital) attended the deceased from. 19\_\_\_\_, that (1) (we) last and that death accurred of PM, from the causes and an the date stated above. saw the deceased alive an DIRECTOR 22a. SIGNATUR ATTENDING PHYS. MED. M.D. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) DATE THEREOF 23g. BURIAL, CREMATION. OF CEMETERY OR GREMATORY 23d. LOCATION (City, town, or county) (State) MOVAL (Specify 0 24. FUNERAL DIRECTOR'S SIGNATUR 25a. REC'D BY GISTRAR 25b. REGISTRAR'S SIGNATURE willing & Krous DATE 1SM 9/59



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE 79 AND DICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Rasidance before admission) a. COUNTY b. COUNTY Chase, Montgomery y is necessary director. Page Maryland Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Board of L write RURAL end give neerest town) Sykesville 1/4yrs.7mos...
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) 14yrs.7mos.12dys Chevy Chase a. IS RESIDENCE ON A FARM? retained he State B Springfield State Hospital 4504 Ridge Street YES NO X NAME OF 4. DATE Month DECEASED OF (Type or print) DEATH Wolford July 10 1961 Hollingsworth George M. W. 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In yeers | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthdey) Months ithin 24 hours after of . Give Pages 1, 2, an orm PM3. Page 5 m orm PM3. Page 5 m . File pages 1 and 2 went within 72 hour WIDO WED DIVORCED 62 yrs. Ma.le White 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if retirad) U.S.A. Maryland Bicycle repairman 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Harry C. Wolford Elizabeth M. Allison e should be executed within 2 ling" in pencil in Item 18. Give ac's Office along with form P as a burial-transit permit. File it removal, and in any event 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO.! 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give weror detas of service) Springfield Hospital Records No None 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN Minutes PART I. DEATH WAS CAUSED BY: Acute myocardial infarction IMMEDIATE CAUSE (a) DUE TO Years Coronary arteriosclerosis Conditions, if any, which ' (b) "pending" gava rise to immediata cause DUE TO ease execute the certificate, writing the word "pending should be forwarded to the Chief Medical Examiner's **FUNERAL** DIRECTOR: Page 3 should be used as (a), steting the underlying cause last. cremation, o PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 8UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) | 19. WAS AUTOPSY PERFORMED? Paranoid condition, plus Friedreich's ataxia. YES NO . 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of Injury in Part I or Part II of Item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. to the Circ. 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, ! 20f. (City or town) (County) (Stata) factory, street, office bldg., etc.) While \_Not Whila at work - at work prior 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection X Inquiry K and in my opinion Natural causes X death resulted from: Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINER'S 7-10-61 James T. Marsh, NAME (Type) Addrass (Street, city, town, or county) 22c. NAME OF CEMETERY OR CREMATORY 22a, BURIAL, CREMATION. 22b. DATE THEREOF 22d. LOCATION (City, town, or country) (State) REMOVAL (Spacify) Rockville, Maryland Rockville Cemetery 040 6 Burial 24a. REC'D 8Y REGISTRAR | 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR VS. A15ME arthur S. Frans Robert A. Pumphrey Bethesda, Maryland DATEJUL 13'61 5M 7/59

RYLAND STATE DEPARTMENT OF HEALTH

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	MARYLAND STATE DEPARTMENT OF HEALTH
7221	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH
1003	CERTIFICATE OF DEATH

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1	a. COUNTY Carrol	1	MARYLAND	g STATE	nere deceased lived. If institut b. COUNTY	1	befare admission)  City
		f outside carporate limits, we arest tawn)	rite c. LENGTH OF STAY IN 16 3 mos. 16dys.	c. CITY OR TOWN (IF o	outside corporate limits, write		
	d. NAME OF HOSPIT OR INSTITUTION	AL (If not in hospital, give s	street address)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?
	Spring	field State	<u>Hospital</u>	3512 Hil	Ismere Road		YES NO
	3. NAME OF DECEASED	First	Middle	Last	4. DATE Mor	nth	Day Year
	(Type ar print)	Mary	Abbiegal	e Yealdhall	DEATH Ju	lv	10 1961
	5. SEX	6. COLOR OR RACE 7.	MARRIED T NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years last birthday)		YEAR IF UNDER 24 HRS.
	Female	MITTO	DOWED DIVORCED	November 18,	1883 77 yrs.		Days Haurs Min.
	10a. USUAL OCCUPATIO	ON (Give kind of wark dane king life, even if retired)	10b. KIND OF BUSINESS OR INC	USTRY 11. BIRTHPLACE (State	ar fareign country)	12. CITIZE	EN OF WHAT COUNTRY?
H	Bookkeeper/H		_	Marvla	and	U.	.S.A.
	13. FATHER'S NAME			14. MOTHER'S MAIDEN N			
	George Ni	chols		Susan Gr	reen		
_	15. WAS DECEASED EVE	R/IN U. S. ARMED FORCES? (If yes, give wor or dates of service)		INFORMANT	Ado	dress	
/	No	(if yes, give wor or dome or service)		Springfiel	ld Hospital Re	cords	
		ATH [Enter only ane cause	per line for (a), (b), and (c).]				INTERVAL BETWEEN
	PART I. DEA	TH WAS CAUSED BY:	Heart failure				days
	42	DUE TO					
	Canditians, if a	ny, which	Arteriosclerotic	heart disease			years
	gave rise to i	mmediate (					
	lying cause last.	the under-					
	PART II. OTH C. B.S. Diabet 20g. ACCIDENT WAS OR CONTRIBUTING OR CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTING OR CONTRIBUTING	with cerebra	ons contributing to DEATH B al arteriosclero Bronchopneumon	osis with psych	nal disease condition GI notic reaction	VEN IN PART	1(a) 19. WAS AUTOPSY PERFORMED? YES NO
	20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY		. DESCRIBE HOW INJURY OCCUR		Part I or Part II of item 1B.)		
	ZOc. TIME OF INJUR Haur a. m. p. m.	V		PLACE OF INJURY (Hame, farm factary, street, affice bldg., etc.		(Ca	ounty) (State)
	21. I certify that		ttended the deceased from $-10-$ 19 $61$ , and that				1, that (I) (we) last
	22a. SIGNATURE	stri cles	11 11 1 1 2		ED. STAFF	nd dir ine	22b. DATE SIGNED 7-10-61
	( 22c. PHYSICIAN'S NAME (Type)	in del Campo,	- //	22d. ADDRESS	eld State Hosp	ital	1-10-01
	23a. BURIAL, CREMATIO REMOVAL (Sporty)		23c. NAME OF CEMETERY		23d. LOCATION (City town,		Mising
	24 FUNERAL DIRECTOR	SSIGNATURE	1 // MODRESS	1 6 / 25a. REC'		SISTRAR'S SIGN	
	ToNer C	formy DT	X al many	DATE DATE	L 21 '61 a	nthus S. t	Challen

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 7835 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If Institution, Residence before edmission a. COUNTY b. COUNTY Carroll MARYLAND Balto.City b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest town) write RURAL end give nearest town) Sykesville 5mos.13days Baltimore 6 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 3621 White Ave. YES NO TO 3. NAME OF Middle DATE Month DECEASED OF Alvin (Type or print) Zschunke DEATH 14. 1967 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH 9. AGE (In yeers | IF UNDER I YEAR IF UNDER 24 HRS. ag hirthdey) Male July 6, 1879 WIDOWED [ 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & Stete, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Maryland Accountant U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please Gothold Zschunke Ernestine Theme 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give wer or detes of service) Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Septicemia IMMEDIATE CAUSE (e) Davs -fransit DUE TO Infected bed sores Weeks (b) gave rise to immediate ceuse DUE TO (a), steting the underlying C.B.S. assoc. with senile brain disease with psychotic reaction.

19. Was autopsy performent. CERTIFICATION NO X 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20f. (City or town) (County) (Stete) factory, street, office bldg., etc.) While Not While et work at work 21. I certify that (I) (this hospital) attended the deceased from February 1, 1961 to July 14, ..., 19.61 that (I) (we) last July 14. 19 61, and that death occurred 4:15AM from the causes and on the date stated above saw the deceased alive on..... 22b. DATE 220. SIGNATURE 7/14/61 IGNED ATTENDING DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Julian Radcykowycz / M. D Springfield Hospital. Sykesville. Md. 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL, CREMATION, | 23b. DATE THEREOF 23d. LOCATION (City, town or county) (State) MOVAL (Specify) 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE VR A15 (4) 15M 9/60 DATE .... 1 8 '61

RYLAND STATE DEPARTMENT OF HEALTH

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